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ABSTRACT

The National Rehabilitation Association annually sponsors the Switzer Memorial Seminar, a program designed to explore, in-depth, a particular topic of interest to the rehabilitatin of handicapped individuals. Participants are selected for their achievements and involvement in the area to be studied. This monograph of the proceedings of the Fourth Switzer Memorial Seminar was developed to stimulate thinking and action in rehabilitation of the mentally ill in the 1980's. Action papers written specifically for the seminar focus on: (1) defining rehabilitation of the mentally ill: (2) coordinating services; (3) reducing disincentives; (4) describing existing model programs; and (5) enhancing the rehabilitation process through post-employment methods. Each paper is presented as a separate chapter, followed by excerpts of comments and reviews by the seminar participants and a summary of recommendations for action. Recommendations are provided for policy and program development, service delivery, research, personnel training, and legislation. (Author/NRB)

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REHABILITATION OF THE MENTALLY ILL IN THE 1980's

EDITED BY LEONARD G. PERLMAN, Ed. D.

CG 014496

A REPORT OF THE FOURTH
MARY E. SWITZER MEMORIAL SEMINAR
NATIONAL REHABILITATION ASSOCIATION

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

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A MEMORIAL TRIBUTE

TO MARY E. SWITZER
1900 - 1971

Few people realize that she had a satisfying and fully successful career in federal government employment that spanned several decades prior to her formal entry into the field of rehabilitation. She was fifty years old when she became director of the Office of Vocational Rehabilitation in 1950, and she brought to the position a superior intellect and ability. Her many talents and experiences in economics, the legislative process, government administration, health, welfare and public education were only a few of the composite assets brought with her. She entered the movement at a crucial point in its evolution. It was a time in which difficult decisions had to be made between maintaining the status quo or moving to a larger and unknown future but with increased opportunity to serve tens of thousands of disabled persons yet in need.

Following a life pattern in support of increased services to people and a more responsive and humanitarian government to changing human needs, she readily committed herself to the less certain but more hopefully expanded future for rehabilitation. The rest is history. The breadth and humanity of Mary Switzer are stamped forever in the passage of Public Law 565 with its research and demonstration features, its concern for rehabilitation education, its mandate to construct necessary rehabilitation facilities, its totally new characteristic of international efforts and cooperation regarding rehabilitation, and perhaps, above all, in its expanded funding base for more personnel and programs for those in need of rehabilitation services. In the years that followed, she went on to even greater legislative and governmental leadership heights in behalf of both disabled and disadvantaged people.

(continued on back inside cover)

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FEBRUARY 1980

EDITOR: LEONARD G. PERLMAN, Ed.D.

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FOREWORD

The National Rehabilitation Association is pleased to honor the memory of Mary E. Switzer by presenting this publication to those individuals who are interested in seeking a deeper understanding of mental illness; its causes and implications, and the challenges presented by this disability. The impact of mental illness is felt by individual families, communities and the economy. Most importantly the problems, social pressure and unacceptance that mental illness presents to the victim warrants a serious and intense effort by all concerned to identify the diverse problems associated with these disabilities, and the need for generating potential change.

Not too long ago individuals subject to mental illness did not fair very well in our society. Today we have seen improvement in the body of knowledge relating to, and the treatment of these problems, however much remains to be done. The discrimination practices in housing and employment remain with us. The challenges of meeting the needs of the post-hospitalized individual in the community and on the job likewise remain. It is our desire that this consortium of talented professionals, under the most capable leadership of Dr. Mildred Mitchell Bateman, will cause us to think, share ideas and then act.

It is in this vein that Mary E. Switzer would be pleased. Mary E. Switzer is recognized as one of the most profound thinkers in the history of the rehabilitation movement. Yet possibly her greatest talent was her tendency to be much more than a thinker; she was a doer. Our challenge is more than to analyze data or identify problems. Our challenge is to be activists for change. If this publication contributes toward that type of change, we will be appropriately promoting the memory of Mary E. Switzer.

Michael A. Oliverio
President
National Rehabilitation Association

ACKNOWLEDGEMENTS

The Fourth Mary E. Switzer Memorial Seminar was made possible by appropriations from the Switzer Memorial Fund, the Postgraduate Center for Mental Health through the support of the National Institute on Handicapped Research (NIHR) and the Mary Duke Biddle Fund. It should be noted that funds were initially raised in a national campaign to establish a memorial to the late Miss Switzer who is remembered by this monograph.

Appreciation is expressed to the Seminar Planning Committee, led by James E. Ramseur, for their excellent guidance in the development of the Seminar, to George A. Engstrom of NIHR for his advice and consultation, to Henry Williams, Chairperson of the Commission on Professional Concerns, and to the members of the Switzer Memorial Committee of NRA for their direction and constant encouragement.

Special thanks go to the "Switzer Fellows" whose thoughts and recommendations are presented in this report, to Mildred Mitchell-Bateman, M.D. for her excellence in chairing the Seminar, to Harry Sands, Ph.D. of the Postgraduate Center for Mental Health for hosting the Seminar and to Barbara Fox and the staff of this Center for their able coordination of the many vital details that went into this project and to Gerry R. Perlman for her editorial assistance in the preparation of this monograph.

Gratitude is extended to Mrs. Olive K. Banister, Chairperson of the Switzer Memorial Committee (whose term of office has recently expired) for her guidance and tireless efforts since the inception of this memorial tribute and to the many donors to the Switzer Memorial Fund who helped to perpetuate the memory of a great leader in the field of Rehabilitation.

L.G.P.

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PRELIMINARY NOTES AND DEFINITIONS

There is nothing new under the sun. Thus the considerations at the Fourth Annual Mary E. Switzer Memorial Seminar provided once again for the process of taking a "new" perspective on old problems ... and a renewed concensus on the value of finding better applications of existing knowledge for the rehabilitation of persons with mental illness.

As the 1979 Switzer Fellows began to discuss the formally prepared papers on the overall theme, Rehabilitation of the Mentally Ill in the 1980's, we realized the need for clarifying and unifying our rehabilitation language. The two most persistently used terms, of course, were "disability" and "rehabilitation".

While some efforts were made during the seminar to define these terms, it seemed better to delay the writing of these definitions until the report of the first Switzer Memorial Seminar could be reviewed. This seemed especially prudent since that first seminar had as its primary focus the development of a "concensus concerning the meanings of 'pathology', 'impairment', 'functional limitation', and 'disability' so that these terms and concepts can become more efficiently useful in rehabilitation research policy, programs, and practice."

For our purposes, we will be concerned with two of the terms noted above. Realizing that there is some danger in lifting these terms out of the context of the report, the reader is urged to review the full report of the First Switzer Memorial Seminar.

"Disability can be defined as a form of inability or limitation in performing roles and tasks expected of an individual within a social environment". The condition of being disabled may be brief as during an acute illness, but in rehabilitation we are mostly concerned with the disability that accompanies, or remains as a residual of, very severe physical or mental illness. These tasks and roles are organized in spheres of life activities involved in self-care, education, family relations, recreation, economic life, or employment and vocational concerns.

It is interesting to note that in the instance of mental disorders, the author points out that there is no clear separability between the "indicator of pathology, impairment, functional limitations, and disability."

With the development of the latest Diagnostic and Statistical Manual (DSM III) under the auspices of the American Psychiatric Association, the delineation of the pathological process, in terms of the areas of the psychological structure which are impaired, should begin to provide greater transferability of understanding of the nature and degree of disability than has occurred in the past.

If we are to build on the concepts promulgated by the First Switzer Memorial Seminar, "handicap" is seen as the popularized, and overall reference term for legislation, and for the development of public support, etc. As

such, the word "handicap" is defined in many contexts in the same manner as we have defined "disability". However, the word handicap should probably not be used as a technical term in research, treatment, or program development.

It would be difficult at this time to consider any discussion of definitions complete, without including a number of other terms, however, we will limit ourselves to the following:

1. Treatment: The sum of methods directed specifically to the cure, amelioration or stabilization of the presenting (psycho) pathology.

2. Rehabilitation: The sum of measures applied to reduce the extent of disability resulting from the (psycho) pathology.

3. A Rehabilitation Outcome: is the targeted improvement of a disabled person's ability to live and work in their particular environment.

4. Competence: is the positive statement of the individual's abilities and assets for achieving desired functioning levels in social and vocational areas. Development of rehabilitation outcomes and goals for individual from the point of existing competencies and the potential for developing new ones could provide greater incentives for making the transition from patient/ treatment to client/rehabilitation.

5. Community: A non-institutional location where people live, learn and work. The community includes physical aspects of the immediate environment as well as influences stemming from the interpersonal, social, legal and organized agency activities that impinge upon a person in that community.

It is readily seen that, since the functional impairment caused by the mental or emotional disorder is manifested through the very elements that must also measure the degree of disability - it often becomes difficult to determine where "treatment" ends and "rehabilitation" begins. A greater understanding of this interplay and its significance for policy, programming and staff development, is one of the goals of this Fourth Switzer Seminar.

Mildred Mitchell-Bateman, M.D.
Chairperson
Fourth Switzer Memorial Seminar

INTRODUCTION

Each year, as a living tribute to the memory of a great leader in the field of Rehabilitation, the National Rehabilitation Association, through the Mary E. Switzer Memorial Fund, sponsors a special program. These programs have come to be known as the Switzer Memorial Seminars and they explore in-depth a particular topic of vital interest to the rehabilitation of handicapped individuals. Usually about 18 persons, selected for their achievements and involvement in the area to be studied, are selected to participate and are designated as "Switzer Fellows" by certificate. The outcome of each Seminar, documented in the form of a monograph, is expected to stimulate current thinking and action in a given area of rehabilitation. Recommendations for action are provided for policy and program development, service delivery, research, training and legislation.

The Current Seminar

The Fourth Annual Mary E. Switzer Memorial Seminar was held in New York City from October 31 through November 2, 1979 and was hosted by the Postgraduate Center for Mental Health. The topic was The Rehabilitation of the Mentally Ill in the 1980's.

The Switzer Fellows were welcomed by Basil Scott, Ph.D., Commissioner, New York State Office of Vocational Rehabilitation, Richard C. Englehardt, Regional Director, RSA Regional Office II, James E. Ramsuer, M.A., Director, Central Islip Psychiatric Center and Harry Sands, Ph.D. of the host organization, the Postgraduate Center for Mental Health.

Special memorial tributes were given by Richard M. Switzer, Assistant Commissioner, New York State Office of Vocational Rehabilitation (and nephew of the late Miss Switzer) and Irving Blumberg, Director, International Committee Against Mental Illness.

In a special message to the Switzer Fellows, Robert R. Humphreys, Commissioner of Rehabilitation Services, HEW, offered the following remarks:

> Mary Switzer would, I am sure, be as pleased as I am that this Seminar established to honor her memory is being devoted to the rehabilitation of people disabled by mental illness. Those of you who were active in the field of rehabilitation during the years of her great leadership will recall the concern she often pressed for greater efforts in assisting persons with psychiatric impairments to regain the fullest measure of independent living, and her recognition of satisfying work as a key ingredient in the restoration process. Far ahead of her time in envisioning the currents of the future, Mary pioneered in advocating special programs on the grounds of institutions designed to prepare mentally ill individuals for the transition to what has come to be known as "the least restrictive environment" in the community. She would, I believe, also share my optimism on the outlook for further significant advances in psychiatric rehabilitation as we move into the decade of the 80's.

A brief review of how some of RSA's resources are being deployed to achieve our ultimate goal of improving the quality of rehabilitation services for greater numbers of people severely handicapped by mental illness affords credence for this optimism. In the development of qualified personpower, three internship-type training courses are being conducted: one at the Nebraska Psychiatric Institute; another at the Human Services Training and Research Council, which is associated with the University of Virginia; and the third administered by the Massachusetts Rehabilitation Commission for personnel from the New England States. Commencing in 1977, we expanded the scope of our Special Projects for Severely Disabled Individuals program to the area of mental illness, and are now funding nine such projects aimed at meeting the comprehensive service needs of this disability group. Although our own appropriation contained only sufficient funds to support a single new project in mental illness last year, NIMH transferred money to RSA which permitted the initiation of three additional projects. This transfer of money is certainly in accord with the spirit of the Cooperative Agreement completed between NIMH and RSA in June 1978, and we are grateful indeed.

Increasingly, the Projects With Industry (PWI) program is helping mentally ill individuals to enter the competitive labor market. The PWI at Fountain House here in New York and the one at the Menninger Foundation, Topeka, concentrate their services on this population, stressing the Transitional Employment Program (TEP) concept. Finally, but perhaps most noteworthy as a foundation for developmental activities in the decade ahead, is the new Boston University Mental Health Research and Training Center. Jointly funded by NIMH and RSA, this Center has the potential for stimulating important advances not only in research and training, but also in fostering innovative approaches in responding to the service requirements of mentally ill people.

At present, well over 20% of the persons served by the State rehabilitation agencies in a given year have a mental disorder as their primary disability. Numerically, this translates to nearly half a million people, and one can only conjecture as to what this figure may be ten years from now. We know that the professional expertise you bring here to the Postgraduate Center for Mental Health as Switzer Fellows will create a monograph that reflects the best thinking available on the most effective methods for rehabilitating mentally ill people at the optimal level of functioning within their capabilities. For the expenditure in time and effort spent in this task, you have our deep appreciation.

Format of the Seminar and the Findings

"Action Papers" were written specifically for the Seminar and focused on the definitions of rehabilitating the mentally ill, coordinating services, reducing disincentives, existing model programs and enhancing the rehabilitation process through post-employment methods. The Seminar provided a forum to review these issues as they related to the mentally ill rehabilitant and to set some positive directions for the decade of the 1980's.

The three-day program of intensive discussion culminated in a number of recommendations for action in the areas of policy and program development, research, service delivery, training of personnel and legislation.

The format of this monograph closely follows that of the Seminar itself. Each paper, which served as a stimulus for discussion, is presented as a separate chapter. Immediately following the paper are excerpts of comments and reviews by the Seminar participants followed by a summary of recommendations for action. These recommendations represent a distillation of the concensus of the Switzer Fellows.

The fourth and fifth chapters present two distinct programs serving the mentally disabled. Again, some reviews and comments are presented to further stimulate thought and action in serving the population under study. Chapter six is the last chapter and is an invited paper from the host agency that summarizes some initial findings of their current three-year project regarding Post-Employment Services for the mentally ill client. The emphasis, in this case, is helping the former psychiatric patient maintain employment after it has been obtained.

While all of the recommendations may not appear to be innovative or dramatic, it was the opinion of the Switzer Fellows that many basic ideas have yet to be implemented and, therefore, will appear as sound suggestions for future planning and action. Whether or not you are in agreement with the recommendations is probably secondary to your own interest, involvement and action in behalf of the mentally ill, as we enter a new decade.

It is the hope of all persons involved in this Fourth Switzer Memorial Seminar that this monograph will not remain on the bookshelf, but will be used in the challenge before us -- better services to those mentally ill persons in our society. Only then will this memorial to Mary E. Switzer have been worthwhile.

CHAPTER ONE

WHAT CONSTITUTES THE REHABILITATION OF THE MENTALLY ILL IN THE 1980's?

AUTHOR: ROBERT J. GRANTHAM, Ph.D

SUMMARY OF PAPER

This paper provides a comprehensive historical view of the concepts of what rehabilitation of the mentally ill has meant to both the rehabilitation and mental health fields over the past 60 years and reviews the various federal rehabilitation and mental health laws. It pointed out that it is during the last decade that the rehabilitation field has begun to move to treating the severely disabled and has taken on a holistic view of the individual rather than stressing only the vocational. Mental health values have moved from an emphasis on personality reconstruction to that of adjustment of both the client and his environment. Recent trends in mental health are seen as adopting the human services ideology which calls for systematic integration, comprehensiveness and accessibility, dealing with problems in living and with less emphasis on professional boundaries and more emphasis on service provider accountability. The author also deals with the realities of an ongoing resistance to writing-off the severely disabled as unserviceable. Reviewing some views of the future of rehabilitation of the mentally ill, the author reports that studies indicate greater emphasis on management of the social environment where the rehabilitation counselor may function more as a case manager and have less time to pursue psychological counseling skills. The paper concludes with an analysis of the NIMH community support program (CSP) as providing a meeting point of rehabilitation and mental health philosophies. He talks of the significance of the NIMH/RSA agreement that weds these two agencies and that rehabilitation will not be done in isolation.

-- Robert D. Ray

INTRODUCTION

A clear and consistent definition of rehabilitation is difficult to come by. One must search arduously through the rehabilitation literature to locate this "golden pearl." The frustrations encountered along the way remind me of Robert Frost, the noted poet, who spoke of coming to a fork in the road and having to choose between two alternatives. Imagine Mr. Frost's dilemma were he a practitioner in rehabilitation, or mental health for that matter, and were faced with no fewer than three alternatives.

The initial part of this search is begun in an atmosphere of great enthusiasm. At the other end lies the "true" definition of rehabilitation for which we have been searching for over sixty years. Surely the prize must be of great consequence to have commanded this much time and energy on the part of so many people.

The use of fantasy in the introduction is consistent with the task ahead of me. For only in fantasy can one contemplate achieving clarity in this highly complex task. Others of greater knowledge and wisdom have journeyed this way and have labored longer and more productively in the vineyards than I. Yet, even these worthy men and women have only been able to grant us clues to unlocking the mystery which lies ahead (Nagi, 1965a, 1965b; Scwartz, 1953).

It is with great trepidation that I approach the task of defining what constitutes the rehabilitation of the mentally ill. My search of the literature would lead me to believe that this task is guided by several key questions: What is rehabilitation? What is mental illness? How do these two systems interact? Once these questions can be answered, it may then be possible to define rehabilitation in the mental health context. This real journey will occupy our time in the remaining pages of this paper.

WHAT IS REHABILITATION?

A review of the literature suggests at least three dominant themes in our efforts at defining rehabilitation. The first theme is vocational or work-related. Second, a medical approach has had enormous impact on the field. The third theme, and the latest, will be labeled the competence or community rehabilitation model.

As the above threads have run through the history of rehabilitation they have not been visible in pure form. Rather, they have been intricately woven into the fabric of the evolving panorama. The vocational and medical themes have run concurrently with emphasis more or less on each at a given time. The initial thread was vocational (Smith Hughes Act, PL 64-347, 1917; Veterans Rehabilitation Act, PL 65-178, 1918; Smith-Fess Act, Vocational Rehabilitation Act of 1920, PL 236).

The emphasis on medical activities had to await the Barden-LaFollete Act of 1943 which extended rehabilitation services to include the "provision of corrective surgery, therapeutic treatment, hospitalization, transportation . . . . medical examinations, guidance and placement. Special provision was made for rehabilitation of the blind and rehabilitation of persons having mental disabilities" (Kranz, 1960, p. 27). Further, Bloom (1965) asserts that "the concepts of rehabilitation have been derived mainly from work done with the physically disabled" (p. 116).

The competence or community rehabilitation model has a number of organizing principles. Lamb (1977) summarizes ten principles that form the philosophical foundation for efforts in community rehabilitation. The list includes the following:

1. Rehabilitation should be primarily in the community.

2. The rehabilitation plan needs to be comprehensive, including social and vocational rehabilitation, individual or group psychotherapy, psychoactive drugs if needed, financial assistance and the provision of a supportive living arrangement if required.

3. A high priority should be given to learning "in vivo."

4. The goal is to focus on the healthy personality.

5. The focus should be reality factors rather than intrapsychic phenomena, and on changing behavior rather than changing basic character structure.

6. In working with chronic patients, high but realistic expectations must be maintained so patients can strive to attain their full social and vocational potential.

7. Rehabilitation efforts should be aimed at giving the patient a sense of mastery over his internal drives, his symptoms, and the demands of his environment.

8. An "institutional alliance" develops among psychiatric patients in which they relate more to the institution than to an individual.

9. Relatives are more to be relied upon as primary care agents.

10. Rehabilitation goals must be clearly defined in each phase of rehabilitation.

A distinguishing factor about the social, emotional competence model is that the environment plays a large part in the conception of rehabilitation. It is evident that the goal of rehabilitation under this rubric is to develop individuals to the point where they can cope with their residual disability and at the same time achieve their maximum psychosocial and vocational potential.

The competence model suggests an optimum toward which one strives. In truth, this approach allows us to conceptualize a number of areas of functioning, each with its own developmental tasks. Individuals are seen as progressing to various points on a series of dimensions. Consequently, an individual can be viewed as limited in some areas and adequate in others.

The above conceptualization includes the medical and vocational models by expanding these notions to include the influence of the environment and the positioning of life functions on separate dimensions. Work can be thought of as something to be enjoined or disengaged; medical impairments can be seen as related to loss of functioning, but not necessarily handicapping.

Another distinguishing aspect of the competence model is its relationship to fitness or ability. The competence of an organism means its fitness or ability to carry on transactions with the environment which results in it maintaining itself, growing, and flourishing (White, 1959). Kaplan (1976) labeled this conception as motivational to be added to libidinal and tension-reduction drive theories of the psychoanalytic and behavioristic schools respectively (p. 6). He suggests that if one were "to add to fitness and ability, additional concerns related to progress and movement in the direction

of increasing fitness and ability within predictive limits to the degree to which man can be "in charge . . . one acquires additional backers Allport (1955), Johada (1958), Maslow (1954) and Rogers (1958)."

Rehabilitation defined as competence provides the practitioner with a way to integrate the medical and vocational constructs into an environmental context bracketed by levels of achievement. We can still focus on the fitness or abilities of the individual as long as we recognize that there are numerous tasks to be mastered - work and physical functioning among them.

The competence model would seem to be more in keeping with the early conceptualizations of rehabilitation which focused on the whole being (Whitehouse, 1960; Wright, 1960), the more recently understood necessity to take the environment into account (PL 333), and the emphasis on the severely disabled (PL 93-112 as amended).

Generally the three trends detailed so far have impacted our thinking regarding a definition of rehabilitation. Clearly the vocational and the medical are singularly inadequate to define the scope of the problem. Furthermore, a suitable definition must take into account the context in which it will be used. For our purposes the definition must be adaptable to the mental health context. At this juncture I would lean in the direction of a definition which had a competence base.

To determine the utility of competence as a basis for deriving a definition of rehabilitation we must achieve some understanding of competence within a mental health context. To do this we will review the equally elusive area of mental health to come to grips with the parameters within which we must work.

WHAT IS MENTAL HEALTH?

Several schools of thought exist from which to define mental health and its treatment system. A quick review of some of the issues associated with the definition will be presented to establish the appropriate context for discussion.

Kaplan (1976) points to four general theoretical attempts to define mental health which are both historical and cumulative in their effect. The particular theories he reviews are (1) absence of illness, (2) adaptive behavior, (3) social conformity, and (4) competence.

The absence of illness approach is categorized as the historic medical approach. This view relates mental illness to biologic processes. The mind was considered to be a physiological component of the body and capable of study using traditional medical tools and techniques. Even Freud, however, conceded that mental phenomena could not always be related to organic structures. He added new concepts to his widening grasp of the mind to accommodate the deficiencies encountered using this approach.

Kubie (1975) cautions us against the physiological view of mental illness by indicating "There is no such thing as 'the ego' anymore than there is the 'conscious' or the 'unconscious' or the 'preconscious' . . . there are ego

functions, conscious processes, preconscious processes, unconscious processes . . . we have no right to use nouns at all, because as soon as we do we become vulnerable to anthropomorphic thinking and the reification of abstractions. Nouns create images of little homonuclei inside us" (p. 15).

Another attempt at the definition of mental health derives from the concept of adaptive behavior. "This approach sometimes referred to as the psychological or behavioral model, does not distinguish between healthy and sick behaviors. Instead, it postulates that modes of adjustment are continuous along a desirable - undesirable dimension whose definition rests essentially with important people in the individuals environment (Krasner & Ullmann, 1965; Ullmann & Krasner, 1965)."

Kaplan (1976) further indicates that the psychological model relates behavior to its specific social context, "inferring the peculiar contradiction that it is, in terms of its specificity to context, not aberrant at all" (p. 5). This viewpoint makes it quite clear that behavior is an outgrowth of something other than the presence or absence of disease processes. Instead, the criterion of adjustment or adherence to social norms is substituted.

Proponents of the behavior view have been aware of their failure to account for processes which refer to mental activity, i.e., thought, awareness, affect, etc. Yet they and others concluded that the alternative to strict behaviorism does not have to be mentalism (Franks & Wilson, 1974, p. 7 in Kaplan, p. 5).

The third definition, social conformity, proposes mental health as "conformity to the social situation in which a person is embedded or to a condition towards which he aspires" . . . (in Kaplan, 1976, p. 5). However . . . "to equate mental health and social conformity is to overlook the possibility that the social context itself may be 'sick' or productive of 'maladaptive' behaviors in relation to more compelling sets of standards" (Kaplan, 1976, p. 5). Numerous researchers such as Sherif (1936), Roethlisberger and Dickson (1939), and Milgram (1963) have demonstrated that behavior can be influenced in a counter direction to previously adopted standards and that conformity in some situations can result in severe inner personal stress which can hardly be defined as a mentally healthy condition.

Another interesting and germane point raised by Kaplan (1976) is that "what is" is often confused with "what ought to be" and this latter norm is the one that unfortunately becomes the standard for mental health. Conformity is a value-laden concept which equates deviance with mental illness.

The last definition reviewed by Kaplan (1976) is that of competence. The term as generally used refers to fitness and ability in a variety of settings. This model adopts a multi-dimensional view of mental health which is dynamic in nature, and includes the changes which occur in the interaction between the individual and his/her environment.

The concept of competence throughout focuses on the notion of adjustment which rests on an evaluation of actual behaviors. Like social conformity and adoptive behavior, the competence notion also fails to adequately account for the concepts of mind and mentalism.

The various definitions discussed have influenced mental health and continue to do so. Each viewpoint has its proponents and detractors. None of the four approaches reviewed has been adequate to explain the holistic view of mental health which interconnects the abstractions referred to as the mind with actual behaviors. Yet, there is compelling evidence to suggest that mental health is currently operating using the competence model which places attention on problems-of-living. The thrust toward CMHC's in the 1960's and the human service, quality of life concepts lead one to conclude that there is less emphasis on altering personality and more concern for providing a wide range of supports to achieve optimum competence. We have ceased looking for a definition and placed more emphasis on the delivery process.

SYSTEMS VIEW OF MENTAL HEALTH AND REHABILITATION

Both rehabilitation and mental health are interrelated yet separate systems of care. They coexist within the human services framework. They share similar inputs (disabled clients), throughputs (processes for providing service), and outcomes (rehabilitated clients).

The interactions and interrelationships between rehabilitation and mental health can be assessed according to Mayer's (1972) notion of socio-cultural change. Briefly, Mayer describes socio-cultural change as a drastic alteration of the relationship between people (roles), basic institutions and value systems. We achieve a better understanding of these issues when we add the notion of domain (Levine & White, 1961) which refers to the specific goals an organization wishes to pursue and the functions it undertakes to implement its goals. More specifically domain in health field refers to the claims that an organization makes for itself in terms of (1) disease covered, (2) population served, and (3) services rendered (Levine & White in Baker p. 375).

By assessing the meaning of rehabilitation in the context of domain consensus and socio-cultural change we are able to view four common elements in the relationship between rehabilitation and mental health. Proceeding in this direction, it becomes clear that the definition of both rehabilitation and mental health in the absence of adequate criteria for each will depend ultimately on the consensus derived out of a shared relationship.

DOMAIN CONGRUENCE

Rehabilitation covers fifteen (15) areas of pathology and functional limitations. Not only are disease entitites or active pathology covered, but rehabilitation also addressed itself to the residuals of these problems and the skills needed to cope with these limitations. Most specific to rehabilitation is its use of work or vocational planning as a means to an end.

Mental health covers diagnostic categories which relate to deviance in thought processes and intellectual functioning as described by the American Psychiatric Association. These categories differentiate deviance from normal behavior. The categories cover both physiological as well as psychosocial problems. They result in mental health addressing itself to deviance in thought processes wherever and in whomever it occurs.

With regard to population served, rehabilitation serves disabled persons in fifteen disability groups and more specifically those with the most severe problems. Some, but not all the populations served by rehabilitation are the

mentally ill, the developmentally disabled, alcoholics, drug addicts and the elderly (PL 93-112). Any member of these groups above sixteen (16) years of age who shows some employment potential is eligible for rehabilitation services.

Mental health services on the other hand, are generally offered to anyone who evidences a need. Traditional service groups, as per PL 94-63 are the mentally ill, the developmentally disabled, the alcoholic, the drug addict, the elderly, children under 16 years of age and rape victims.

The goals of treatment in each instance are similar, yet the emphasis is different. Rehabilitation's goal is to reintegrate the individual into society. Lamb (1976) cites as the goal of psychiatric rehabilitation "to expand the remaining well part of the person instead of to remove or cure pathology" (p.3). Recognized is the need to treat both the individual as well as to alter his environment. Thus the truly integrated individual in rehabilitation's terms will achieve integration through a work role which duplicates his former role or approximates the best he is capable of, given his functional limitations.

The treatment goals in mental health revolve around treating persons in the least restrictive settings, reducing mental disabilities, providing treatment in the community, making a wide range of services available, concentrating on the most severely or chronically disabled, and making services accessible and available to all persons in need.

Reviewing the domain issues it appears as if rehabilitation has cornered the market on vocational pursuits. The scope of services spelled out in the legislation (PL 93-112) is offered in the service of converting the non-working disabled into potential, if not actual workers or freeing-up someone else to be able to perform the work role. Service populations, however, cross organizational boundaries. Rehabilitation provides service to some of the same clients served by the mental health system. The GAO Report (1977) indicates that 38.1 percent of the clients served by rehabilitation are mentally disabled. Usdane (1965) had previously reported that 12 out of every 100 persons rehabilitated were diagnosed mentally ill (p. xvi).

The goals for each service system are similar. Rehabilitation focuses on expanding the remaining well parts of the person while mental health attempts to reconstruct the psyche and provide a therapeutic environment. Mental health is not as concerned about achieving a vocational fit as it is achieving a more global state of happiness. Rehabilitation and mental health are moving toward social/treatment goals which value changing the environment to meet the needs of the client.

REHABILITATION VALUES

The ideological base for rehabilitation produces an interesting paradox for its practitioners. Lamb (1977) outlined a set of principles previously cited which he asserts guide rehabilitation efforts in the community. These principles are largely in keeping with earlier writings by Whitehouse (1960), Wright (1960) and others. Central to each set of principles is the focus on the whole person and the goal of integrating a multi-disciplinary treatment process to match multi-faceted problems.

On the other hand the early legislation (Smith-Hughes Act PL 64-347, 1917; Veterans Rehabilitation Law, PL 65-178, 1918) and subsequent versions of the

rehabilitation legislation (PL 93-112) stress service for vocational purposes. In fact, the legislation has withheld service or greatly restricted same if work were not a potential outcome. In contrast to the expansive notions of early theorists, PL 93-112 dictates that in order to be eligible to receive services there should be "a reasonable expectation that vocational rehabilitation services may benefit the individual in terms of employability" (Sect. 401.33).

The primary value changes that have occurred within the rehabilitation field in the last decade are (1) the move toward service to the severely disabled, and (2) the gradual acceptance of the competence model in addition to work. These changes have caused theoretical and practical problems for rehabilitation. In the rehabilitation of mental health clients, it has forced a concentration on services to a population that has been described as "marginal, socially isolated, vocationally inadequate, and possessed of exaggerated dependency needs. They frequently find it difficult to meet even simple demands of daily living. They lack the ability to withstand pressure and to cope with the common crises of life. The variety of their problem-solving techniques is limited and they are apt to develop incapacitating psychiatric symptoms when confronted with minor life stresses" (Lamb, p. 4).

As has been pointed out by several authors (Olshansky, 1968; Grantham, 1979), rehabilitation must come to grips with the fact that work is neither a viable nor desirable outcome for all those clients treated by the rehabilitation system. This latter point places some strain on the belief system of rehabilitation workers. This strain emanates from a legislative guide which requires services to be withheld if work is not a potential outcome. If we really adhere to a holistic view of the individual we must be comfortable with differential levels of client functioning. These levels may result in a profile in which work occupies low status, yet the whole person is more adequate.

In addition, the rehabilitation philosophy must address its operating propensity to attempt to treat the whole person. Rehabilitation takes on more responsibility as a treatment agent than a categorically oriented treatment system will allow. That is to say, rehabilitation's domain is work and vocationally related areas, yet its practitioners are often more oriented towards comprehensive service delivery in all spheres of functioning. However, unless a truly multi-disciplinary health care system develops, the curtailing of the roles and responsibilities of rehabilitation counselors cannot be accepted if we are to continue to advocate for our clients. A paradox in which all service deliveries find themselves is in reconciling a view of themselves as doing a good job when they know clients are not having their needs met. Accepting one's limits is easy if you know the holes in the system are plugged.

MENTAL HEALTH VALUES

The "Third Revolution" heralded by the passage of the Community Mental Health Centers Act of 1963 (PL 98-164) ushered in a new philosophical base for treatment of the mentally ill. Dorsett (1964) cites the chief aims of the new approach to be (1) to provide service in the community, (2) to locate facilities reasonably near the patient's home, (3) to provide a comprehensive range of services, (4) to make services both immediately available and easily accessible, and (5) to provide continuity of care until restoration or rehabilitation is completed.

Baker and Schulberg (1967) enumerated five elements of an emerging ideological base for service delivery labeled the community mental health ideology (CMHI). These components were reflective of developing social values and thematic ideas among nine mental health criterion groups. The elements were

(1) A population focus, (2) Primary prevention, (3) Social treatment goals, (4) Comprehensive continuity of care, (5) Total community involvement.

While the implications of the CMHI were being more fully defined by Baker and others (Howard & Baker, 1971; Baker & Schulberg, 1969; Bloom & Parad, 1977) a new ideology was taking shape which, while related to the community mental health ideology, is more expansive. This new ideology was labeled the human services ideology (HSI) (Baker, 1974).

The human services ideology (HSI) has as its base, five major themes:

1. Systemic Integration. Effective comprehensive services can be provided only by linking and integrating the various care-giving agencies with their complex array of resources, technologies and skills.

2. Comprehensiveness and Accessibility. Services should be inclusive and available to clients without barriers of a geographic or administrative nature.

3. Problems in Living. Clients' problems should be analyzed with regard to the fit between a person and his/her environment rather than being simply categorized within a diagnostic label.

4. Generic Helping Activities. A universal quality exists in the helping actions of caregivers which transcends disciplinary and professional boundaries.

5. Service Provider Accountability. These providing services are responsible not only to themselves and their colleagues but, more importantly, to clients and the public at large.

There is a seeming correlation between the community mental health ideology and the human services ideology but that relationship is far from perfect (Schulberg, 1977). Current research is being conducted by Baker and his colleagues to establish these relationships.

Critical to the above discussion is that the values espoused in the CMHI and HSI are representative of the direction in which the mental health service delivery system is going. Further, this approach to mental health is clearly on the side of the adjustment school as opposed to the personality reconstruction school. The adjustment it speaks to, however, is an adjustment of both the client and the environment. It is this latter issue which weighs heavily on the implementation of a delivery system organized around these principles.

In summary, it appears as if the rehabilitation values are not that clearly articulated. One derives certain principles from the literature, but is hard pressed to discover those values spelled out in any one place. Thus, it is difficult to determine what beliefs motivate and influence rehabilitation counselors and others in the field. Research of the kind done by Baker and his

colleagues (Baker & Schulberg, 1967; Schulberg & Baker, 1969; Baker, 1974) has not materialized in the rehabilitation field. Consequently, the author, along with Baker has undertaken a national survey of rehabilitation counselors to determine the extent to which they adhere to both the community mental health and human services ideologies.

One must not be left with the impression that the beliefs articulated in the CMHI and the HSI are foreign to rehabilitation personnel. This would not be a true picture of the practice of rehabilitation counseling. Rehabilitation was a pioneer in including the client in the treatment process, working with multiple resources in the community, stressing the need to provide comprehensive service, and recognizing the capability of indigenous helpers. What has not occurred is the organization or and articulation of a set of beliefs which guide our work.

REHABILITATION INSTITUTIONAL CHANGE

Initially hospitals and specially created physical medicine centers played dominant roles in the rehabilitation system. As work became more of a focus, sheltered workshops and administrative offices began to dot the service delivery scene. Greenleigh Associates, Inc. (1975) estimated that 400,000 persons are served in workshops each year. Further, the Annual Report to the President and Congress Fiscal Year 1978 on Federal Activities Related to the Administration of the Rehabilitation Act of 1973 (Annual Report, FY 1978) reports 2.1 million persons served by rehabilitation in fiscal year 1978. Of this group, 294,400 were closed as rehabilitated during fiscal year 1978, a nine percent increase over FY 1977 over 227,000 were serviced in rehabilitation facilities (Annual Report, p. 11).

The emphasis on the severely disabled in PL 93-112 portends the probability of a shift in the location of rehabilitation clientele among the mentally ill. Increases in state hospital discharges will probably show up as increases in treatment in residential programs and outpatient service areas. What will remain, however, is a hard core population of about 150,000 chronically mentally ill individuals for whom services will need to be designed. This view is supported by the Annual Report, FY 1978.

There is a tendency to withhold service to the chronic population. Lamb (1977) cautions against writing off the severely disabled as unserviceable. He suggests instead that we begin to train personnel to deal with these persons and their special needs. This view is stoutly supported by Cotton, Bene-Kociemba and Cole (1979) whose outline of some of the training issues which must be faced by the inpatient staffs of a general hospital applies equally to rehabilitation counselors.

Clearly the bulk of rehabilitation services will continue to be dispensed by administrative offices around the nation. However, the major work with the mentally ill will be done in the 200 half-way houses serving the mentally ill (Robinault & Weisner, 1978, p. 16), the outpatient clinics, sheltered workshops and day-treatment programs. These facilities are no strangers to rehabilitation personnel. As Button (1971) reminds us, rehabilitation services have long

been a part of the community and have well developed ties to educational institutions, business, industry and other service providers.

MENTAL HEALTH INSTITUTIONAL CHANGE

The mental health service delivery configuration has undergone dramatic change since 1946. Beginning at that point the percentage of the population in mental institutions began decreasing (Kramer, 1977). The decrease in the actual number began taking place in the 1950's and 1960's. This process of decreasing the inpatient population is related to changes in Federal policy and such factors as increasing outpatient clinics (Bahn, 1961; Kramer, 1966, 1967), the introduction of tranquilizers in the early 1950's (Cole & Gerard, 1959), the passage of the Community Mental Health Centers Act of 1963, and a number of other factors.

By 1973, CMHC's were already providing the services for 23 percent of the inpatient and outpatient episodes in mental health facilities. This was compared with 12 percent in state and county hospitals. The total number of psychiatric episodes during that period was 5.2 million (NIMH, 1977). In 1975-65 NIMH was supporting 528 community mental health centers (NIMH, 1977).

The shift in population from state hospitals to community based service has been labeled deinstitutionalization. It has had an impact on the composition of persons seeking admission to local psychiatric inpatient units (Cotton et al., 1979). "The trend toward hospitalization in local settings was documented by Redlich and Keller in their review of the changing patterns of mental health care delivery between 1950 and 1975" (Cotton et al., p. 609).

These data clearly point to a shift in the location of services for the mentally disabled. The implications for the community, staff, and the service system are just beginning to be understood.

MENTAL HEALTH ROLE AND STATUS CHANGE

The changes wrought in the system since 1963 have altered the functioning of professionals in increasing ways. A number of factors have influenced the roles of mental health personnel. Among them are: (1) the passage of the CMHC Act of 1963 which paved the way for non-medical leadership of CMHC's, (2) the paraprofessional movement which elevated the status of paraprofessionals, (3) the citizen participation phenomenon, and (4) the changes in the dominant ideology guiding mental health professionals. These and other factors served to influence the roles and functions of mental health professionals.

Baker and Northman (1979) review those issues which have affected the training of mental health administrators. They cite three ideologies which they feel influenced the emerging conceptions of administration in the human services field. These ideologies are the community mental health movement, the "new careers" movement, and the generalist administrator movement.

Another major influence on the roles and functions of mental health personnel has been the adoption of the "Balanced Service System" as a conceptual model within which the Joint Commission on Accreditation of Hospitals assesses

and accredits community mental health programs (J.C.A.H., 1976). According to Schulberg (1977) the "Balanced Service System's overall goal of reducing mental disabilities and their adverse effects requires that the following eight service functions be provided: identification, crisis stabilization, growth, sustenance, case management, prevention, general health, and auxilliary activities" (p. 4). This service configuration has placed more emphasis on a coordinated, administratively tight system. As such, administrative, organizational maintenance roles have achieved new importance.

Mental health has moved from a position in the 1960's where the universe revolved around the CMHC to one where a more prominent role is accepted by a variety of services. The once forgotten state hospital is achieving renewed recognition as a pivotal agent in the service delivery system. Another developing partner in this situation is the community. Scherl and Macht (1979) and Grantham (1978) point out that deinstitutionalization up to now has not had a consensus from either the professionals or the lay community. Some persons in the professional system will have to learn to deal with a host of unresolved issues of territory and cultural shock if community programming is to be a truly cooperative venture. This new role of community liaison person will be of increasing importance in the future.

Baker and Northman (1979) forecast a heavy emphasis on administrative skills such as planning, implementation, evaluation and reporting. They predict that the future system will be more complex, technical and inhabited by more sophisticated clients. It is evident that there is a shift away from the clinical and towards the administrative in the new service configurations of the future.

REHABILITATION ROLES AND STATUSES

The quest for agreement on the roles and functions of rehabilitation counselors has been seriously hindered by the lack of a well articulated set of principles and ideology. As a result, the search for an agreed upon set of activities has run into theoretical and methodological barriers. An excellent review of this situation is provided by Jaques, Kauppi, Steger, and Lofaro (1979). An early attempt at defining the functions performed by rehabilitation counselors was performed by Rusalem (1951). He identified nine functions. Jaques (1959) queried a national sample regarding their role priorities. She was able to determine that creating a therapeutic climate was the most important function. Bronson et al., (1967) identified nine functions performed by rehabilitation counselors which overlapped those of Rusalem (1951).

Muthard and Salomone (1969) used a task inventory of a national sample of rehabilitation counselors to assess common rehabilitation functions. They were able to identify eight such functions. Using interview behavior analysis data Bolton (1974) tried to assess the most important roles and functions of rehabilitation counselors through factor analysis of the correlations between categorized behaviors. Bolton found three types of counselors on the basis of their interview behavior: information providers, therapeutic counselors, and information exchangers.

Education was found to be related to the roles adopted by counselors by both Muthard and Salomone (1969) and Wright and Fraser (1975). Master's level counselors gravitated toward therapeutic roles (Muthard & Salomone, 1969) and supervisors saw paraprofessionals doing less complicated jobs in an agency setting (Wright & Fraser, 1975). "Both these surveys reveal a tendency to see in master's and bachelor's roles a division between the so-called counselor role and the coordinator roles" . . . The two surveys and the . . . interview behavior study, however, suggest that counselors may tend to either assume a counselor role . . . or . . . concentrate instead on some form of information exchange and other service provision" (Jaques et al., p. 65-66).

Viewing the future, Reiff (1977) posits more emphasis on the management of the social environment. He would see the rehabilitation counselor functioning more as a case manager whose duties would revolve around case-finding, financial management, service procurement and community relations. These role activities may be more in keeping with the legislative mandate to find and serve more severely disabled clients (PL 93-112). Such a mandate leaves less time to pursue psychological counseling skills and places more emphasis on case acquisition and management of the system (Grantham, 1978, p. 5).

THE COMMUNITY SUPPORT SYSTEM

Community support programs (CSP) provide a meeting point of rehabilitation and mental health philosophy. It is a program which provides comprehensive services to a broad client population in a manner that promotes dignity. The human service ideology (Baker, 1974) neatly summarizes the CSP. It is a program which provides linkages among agencies, focuses on problems in living rather than personality restructuring, is comprehensive and provides for easy access, relies on the helping skills of people rather than professional labels, and makes available opportunities for consumers and other citizens to have input.

The rehabilitation community is being drawn more into this approach by virtue of an agreement signed by RSA and NIMH (1978). This agreement commits rehabilitation to the community support program. Implied in this agreement is a view of the service world and a set of principles we have adopted as our own. The confluence of circumstance which led rehabilitation to this position have been outlined in this paper.

A word of caution as we move forward in these new relationships may help us to manage some of the problems which inevitably arise in new organizational arrangements. Two major issues appear to confront us in the near future: The rehabilitation domain in CSP's, and the role and responsibilities in the new service configuration.

1. The role of rehabilitation counselors will be less well defined before it is better defined. The impact of evolving rehabilitation ideological changes will impinge on the domain of rehabilitation.

   Given the co-mingling of service populations, problems addressed, and services rendered, it is conceivable that rehabilitation for the mentally ill could become the responsibility of the mental

health system. It would appear to be no real problem for mental health to add a role which functions around vocational counseling, placement and follow through services. The list of services detailed by the CSP (Turner, 1978) leaves this possibility wide open. It remains to be seen whether the RSA-NIMH agreement will forestall this possibility. Efficiency may dictate that the best prepared agency assume program control. In the initial agreements on CSP, control was yielded to NIMH (NIMH, RFP, 1977).

2. The roles and responsibilities of mental health and rehabilitation personnel will become more similar.

   Following from the discussion of domain consensus and the scope of service outlined by the CSP, it is apparent that rehabilitation counselors will be performing roles similar to those of traditional mental health personnel. Given already established professional guilds, it is possible that the differences between and among groups such as social workers, psychologists and rehabilitation counselors in human service settings will lead to role conflicts of the kind that arose during the emergence of the "new careers" movement. Such issues achieved importance as: Who will be at the top of the status ladder? How will new status values be drawn? How will certification be affected? These and other role issues are ahead of us.

Rehabilitation of the mentally disabled in the final analysis will be defined as a competence of problems-in-living issue. It will be geared towards determining whether work contributes to a healthy adjustment and where indicated, assisting in the achievement of appropriate work behaviors. Services will continue to be restricted to persons who have employment potential but those not acceptable for service will be more effectively linked to a comprehensive mental health or health system.

Rehabilitation will not be done in isolation. The cooperative agreement signed by Rehabilitation Services Administration Commissioner Humphreys will lead to increased efforts to coordinate the service of rehabilitation with those of other helping areas. The energy spent on achieving integration will be buttressed by a more sophisticated client population. These individuals will demand more effective and efficient service to which they are entitled.

The mentally disabled will be approached by a service delivery system, which includes rehabilitation, in a manner which places emphasis on assisting persons to function more competently in a number of life areas. Work will be an area of functioning we seek to improve, but we will do so in the context of what is best for the client.

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EXCERPTS OF REVIEWS AND COMMENTS

The following are excerpts of reviews, comments and questions raised by the Switzer Fellows. These are presented to further stimulate thinking as well as action as it relates to the content of the paper by Dr. Grantham.

"The implications for research, policy and program development, service delivery, training of personnel and legislation seem to point to increasing joint efforts in all these areas between the rehabilitation and mental health fields as they interconnect and support each other in a comprehensive program to work with the severely mentally disabled.

To what extent do the implications of Community Support Systems (CSPs) for rehabilitation counselors (as it applies to roles) also involve other mental health professionals, families and communities as a whole, etc.?

CSPs need mental health agency back-up. Which mental health agencies can maintain stability while giving priority attention to the needs of the chronically dysfunctional patient?"

-- Doris W. Dennard, MSW, CSW

"I believe we need to look at the fact that work is not the goal for all patients. For some, work may be a later goal, but this would not help the patient if initially in order to be a part of rehabilitation services, work had to be the potential outcome. Perhaps legislation is needed so that all persons can choose to work or not work and still be eligible for services."

-- Nancy Downes

"There appears to be a lack of awareness among both rehabilitation and mental health professionals regarding the conceptualization of new program models such as the CSP approach. While RSA & NIMH have forged agreements at the federal level, understanding of federal objectives has not been effectively communicated to the field. There needs to be increased federal and state leadership, especially within rehabilitation programs, toward the rehabilitation of the severely psychiatrically handicapped."

-- John Pellitier, M.A., CRC

"Dr. Grantham has provided us with an outstanding review of the historic developments affecting rehabilitation, mental health care and community systems. These are so valuable that one is reluctant to be critical of any element of his paper. Yet, I must express my concern for his conclusions. He views a more integrated, but less role defined system in which social worker, psychologist and rehabilitation counselor (among others) overlap in activity and responsibility.

My reading of the history suggests that rehabilitation has the most to offer clients, and the greatest accomplishments to point to, when it is clear about its focus of vocational goals. While I can support a functional model and competency goals, I believe that when rehabilitation counselors accept such goals for their clients they are adopting the easy path rather than the path in the best interest of the client. It allows the rehabilitation counselor to escape what is difficult - job placement - and to do what she/he may be trained for, namely, counseling. If mentally ill clients have not been employed to date, is it because they are "unemployable" (and thus candidates for a "competency" model) or is it because the rehabilitation system, and the counselors in that system, have not found the condition under which the employer sector can accept and use, productively, those with a history of mental illness?

Grantham searches for a value base for rehabilitation. Isn't it there - i.e., that work is desirable for human well-being and is a right which a society should insure to its population. From such a value base, responsibility of the rehabilitation counselor in relation to rehabilitation of the mentally ill in the 80's becomes clear. The profession has the task of helping the world of work provide the opportunities for the client population."

-- Shiela M. Akabas, Ph.D.

SUMMARY OF RECOMMENDATIONS

The following is the summary of recommendations and implications for action as developed by the Switzer Fellows for the topic of the first paper (The Recorder was Herbert B. Mosher):

POLICY AND PROGRAM DEVELOPMENT

1. Focus all aspects of planning and policy development on a competency-based model of rehabilitation that enables individuals with psychiatric disabilities to obtain the physical, intellectual and emotional skills needed to live, learn and work in the community.

2. Recognize in all planning activities that the rehabilitation emphasis is valid at any point in the treatment process and may be used both to prevent hospitalization as well as to reintegrate persons into the community following hospitalization.

3. Develop cooperative agreements at the state and local levels that clearly plan and define all responsibilities, services and resources of rehabilitation and mental health organizations to ensure a continuum of support services for individuals with psychiatric disabilities.

4. Emphasize vocational outcomes, broadly defined, as a high priority for planning all aspects of service delivery, training, research and legislation in the rehabilitation of persons with mental illness.

5. Plan and develop a consistent set of criteria capable of measuring outcomes in all areas of rehabilitation services, training, research and administration.

6. Expand rehabilitation planning resources to include more input from consumers, employers, labor leaders, health systems planners, media representatives, legislators, community leaders and other significant sectors whose support is essential for effective rehabilitation of persons with mental illness.

7. Establish and fund a mechanism for comprehensive review at all levels of rehabilitation planning, education, research, service delivery and legislation.

RESEARCH

1. Evaluate existing service delivery models for rehabilitation of persons with mental illness to determine what works and for whom.

2. Identify strategies for building the rehabilitation approach into the initial phases of the treatment process for persons with mental illness.

3. Develop research methods to delineate more clearly the specific and interrelated roles for each participant or agency in the rehabilitation effort.

4. Initiate research strategies designed to optimize the balance between client and professional responsibilities in all aspects of mutual participation in the rehabilitation process.

5. Conduct a systematic investigation into broadening the base of financial support from both public and private sectors for all aspects of rehabilitating persons with mental illness.

SERVICE DELIVERY

1. Develop consistent local, state, and regional agreements among all providers of services to persons with mental illness that ensure reasonable access to all services in both rural and urban areas.

2. Target improved rehabilitation services to presently unserved and underserved populations including, for example, troubled adolescents, the severely disabled, minority members, deinstitutionalized patients, the elderly and persons with physical disabilities.

3. Expand the vocational planning process through programs such as Projects With Industry (PWI) to include all aspects of assessment, training, work adjustment, placement and post-employment support systems as part of the total rehabilitation process.

TRAINING OF PERSONNEL

1. In order to implement a rehabilitation approach to the problems of persons with mental illness, new training curricula must be implemented at all levels of the mental health and rehabilitation. This includes students in specific training and short-term training for practitioners already in the field.

2. Training programs must balance the accumulated body of rehabilitation knowledge with the specific technologies to serve special populations such as troubled adolescents, minorities, the elderly and persons with physical disabilities.

3. Explore the use of the private sector and consumer groups as a resource for training rehabilitation personnel.

4. Investigate new criteria for credentialing rehabilitation personnel and facilities to correspond with the competence model of rehabilitation practice.

LEGISLATION

1. Improve enforcement at all levels of existing laws with specific attention to Sections 503 & 504 of Title V of The Rehabilitation Act, and amendments.

2. Encourage required coverage for rehabilitation and mental health benefits from private insurance companies.

3. Allocate additional resources to train rehabilitation personnel in the implications of present laws regarding persons with mental illness.

CHAPTER TWO

REDUCING DISINCENTIVES AND FOSTERING THE REHABILITATION OF THE MENTALLY ILL: A PSYCHO-SYSTEMIC APPROACH

AUTHOR: LES BRINSON, Ph.D.

SUMMARY OF PAPER

Dr. Brinson's paper addressed some important issues in the delivery of services to the psychiatrically handicapped. These include 1) the influence of social and political factors upon the delivery of rehabilitation services and the definition of illness; 2) the problems of ethnic minorities and other populations; 3) the consideration of racial and cultural factors in the service delivery; and 4) the need to maximally involve the client in the rehabilitation process through development of client incentives, especially through removing systemic practices which may actually impede this process. In addition, the point is stressed that clients need to understand the services available to them in ways which are understandable, meaningful and which facilitate client involvement and self-responsibility in the process.

-- John R. Pelletier.

INTRODUCTION

Through the development of modern research methods, varied psychotherapeutic stratagems, and community mental health concepts and facilities, we are persuaded that mental health rehabilitation has traveled a long way from the dark ages of its primitive past where superstitious and evil treatment of persons with mental disorders characterized such times. The story of this journey is a fascinating one, worthy of review in that the clearest view of the future is often best reflected in history.

Perhaps the earliest treatment of mental disorders was practiced by stone-age cave dwellers some half-million years ago. For persons whose mental illness was complicated by severe headaches and convulsive attacks, the medicine man treated the disorder by an operation called trephining. This operation was performed with crude stone instruments and consisted of chipping an area of the skull in the form of a circle until the skull was penetrated. This opening, called a trephine, presumably permitted the escape of evil spirits that supposedly was causing all the trouble--and incidentally--may have relieved a certain amount of pressure on the brain. Selling (1943) reports that trephined skulls show healing around the opening which indicates that many patients possibly survived the operation and lived for many years after the operation.

Scribes of Chinese, Egyptians, Hebrew and Greek literature attributed incidence of mental disorders to demons who would, at the hand of "god", possess the individual for punishment purposes. Christ reportedly treated and cured a man "possessed" or with "unclean spirit" by transferring the devils that plagued him to a herd of swine, who, in turn, became possessed and "ran violently down a steep place into the sea" (Mark 5:1-3). The principal and enduring form of treatment for demonical possession was exorcism, which included various techniques for casting the evil spirit out of the body. The actual form of treatment varied considerably, but, typically included prayer, incantation, noisemaking, and the use of various horrible-tasting concoctions, such as purgatives made from sheep's dung and wine. In extreme cases flogging, made the body of the possessed person such an unpleasant place that the evil spirit would be driven out. Progressively, treatment was transferred from Shaman to priests who were apparently a curious mixture of priest, physician, psychologist, and magician. Despite their continued beliefs in demonology, they did make a beginning in humane and scientific treatment of mental illness.

The Golden Age of Greece marshalled in considerable change in the understanding and handling of mental disorders. During this period a "medical priesthood" discipline was inaugurated. This spawned the development of various "schools" that fostered differential and scientific approaches to mental disorders. It was in one of these schools that the great Greek physician Hippocrates (460-377 B.C.), the "Father of Modern Medicine," was trained and subsequently transformed the focus of treatment from an emphasis on demon theory to germ theory. His position was clear: "For my own part, I do not believe that the human body is ever befouled by a God" (Lewis, 1941, p. 37).

Correspondingly, political and social systems of the world were experiencing similar changes; reflecting an increased value on the individual in terms of individual integrity. Thus Middle Age systems, such as demonology and witchcraft, which generally rendered persons to mysterious and inhumane circumstances were gradually, but assuredly reformed.

The most outstanding reform was initiated with a revolutionary experiment in 1872 by Phillippe Pinel who, under the watchful control of the French governmental and hospital systems, (Revolutionary Commune) removed the shackels and chains from inmates at the Salpetriere Hospital. The essence of the experiment was to test his views that mental patients could be treated with kindness and consideration without their becoming vicious beasts or criminals. The results of the experiment were miraculous. One patient who had been chained and placed in a dark dungeon was later freed to totter outside to see the sun for the first time in forty years. With wobbly legs weak from the lack of use and big tears reflecting his inimitable joy exclaimed, "Oh how beautiful!" (Zilboorg and Henry, 1941, p. 323).

Pinel's work was followed by William Tuke of England, Benjamin Rush and Johann Wayer of the United States. However, the three individuals whose efforts contributed most to the revolution of treatment of patients were Dorothea Dix who educated the public about mental disorders; Clifford Beers, whose popular book--The Mind That Found Itself--described his own mental collapse and told of the shameful treatment he received in the institutions

of the day as well as how he was able to recover in the home of a friendly attendant; and Emil Kraepelin who designed a systematic classification of mental disorder which is still used in both principle and form for psychodiagnostic purposes.

Clearly, these events represent major strides toward fostering respect for the dignity of all persons, a precondition for any effective treatment system. Such accomplishments have undoubtedly inspired the development of the Community Mental Health Centers Act of 1963, and the 1954 and 1965 Rehabilitation Acts that set forth not merely the proper or moral treatment of mentally disordered persons, but required a methodology of accountability, and gainful employment (Murphy, 1969).

While the changes in the treatment of patients have been well received and much overdue, one must ignore the impulse to believe that such changes occurred by happenstance or via some inexplicable enigma. Rather they undoubtedly occurred through the energies of individuals who impacted the political and social systems of their domain which, in the final analysis, determine and control the entirety of their lives and subsequently ours: the lengths of our skirts, the size of our automobiles, the choices of our spouses-fat, short, color, etc. These systems also determine which mentally ill person will be rehabilitated and by what means i.e.; torture, psychotherapy, frontal lobotomy, electroshock therapy, vocational counseling, deinstitutionalization or whatever. Note should be particularly made of the fact that political and social systems define who shall be a patient and who shall not. It follows therefore that the political/social relationship between service providers and service recipients is as important, if not more, than the traditional therapeutic relationship.

Accordingly, it is the purpose of this paper to examine the problems, past and present, of rehabilitating the mentally ill, especially the underserved populations, to estimate the extensiveness of current problems and to set forth some rehabilitation-type strategies to more effectively deal with such problems. The stratagems recommended will emphasize a shifting of the responsibility of rehabilitation (by specific psycho-systemic intervention techniques) to persons needing services and <u>away</u> from those <u>providing</u> it.

CURRENT STATUS AND SCOPE OF MENTAL ILLNESS

It is often conservatively estimated that 15 percent or more of the population of the United States needs psychological or psychiatric care and that the cost exceeds 1.7 billion a year (and is escalating) which represents about 11 percent of all health care nationally (Bryant, 1978).

SCHIZOPHRENIA

According to the 1978 President's Commission on Mental Health, Volume II, schizophrenia continues to be the most widespread and major mental health problem in the country. Symptoms include altered motor behavior, immobilization, purposeless activity, etc. There are disturbances in thought processes,

distorted concept formation, bizarre speech, and illogical thinking. In terms of treatment and diagnosis, there are major disagreements about which criteria are best to apply in the diagnostic and treatment plan. Some studies have shown that antipsychotic medications may be helpful for certain diagnostic types of schizophrenia, but not for others (Evans et. al. 1972). However, there is virtually no evidence to date to show that any current treatment approach to schizophrenia represents a definitive cure (Bryant, 1978).

AFFECTIVE DISORDERS: DEPRESSION AND OTHER MOOD DISORDERS

This category refers to a group of psychiatric conditions in which disturbances of mood predominate. Such disorders are differentiated from disorders of thinking which conventionally include schizophrenia and paranoid states. Persons who are at high risk for developing depressive disorders include those suffering from parental deprivation either by early childhood separation from parents, by having mentally ill parents or being reared within an abusive and rejecting family. Special populations such as women, Blacks, the poor, and single parents are disproportionately represented in this category (Mechanic et. al. 1978). There is substantial evidence that chemotherapy and psychotherapy given over 6 to 8 months is valuable in preventing relapse after symptomatic recovery (Klerman et. al. 1974).

DRUG ABUSE AND ALCOHOL-RELATED DISORDERS

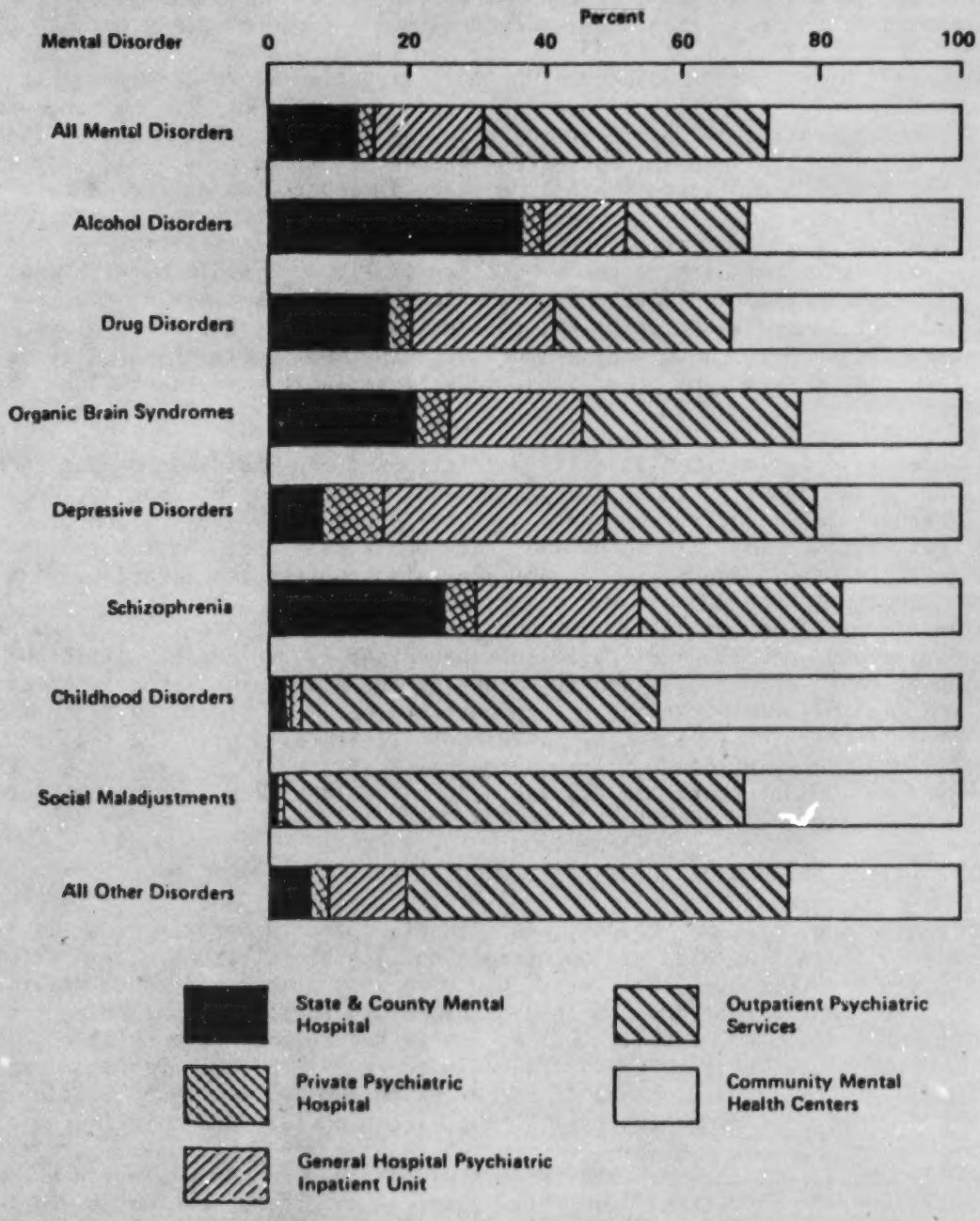
Extensive human disability associated with drug use, including alcohol, continue to pose extremely serious social and health concerns to society. It is a chronic, recalcitrant problem which can be resolved only through sustained, committed effort, greater ingenuity, and multi-faceted research. These disorders also are disproportionately represented by special groups, especially Blacks whose chances for cure or rehabilitation are always less than any other group.

OTHER MENTAL DISORDERS

The first two previously described diseases constitute the largest numbers of mentally ill patients in the United States which is reflected in Figure #1. Substance abuse is not as prevalent, but Blacks and other minorities are heavily represented in this category. Other mental disorders which are also relatively widespread include social maladjustments, childhood disorders, organic brain syndromes, etc. which are also shown in tabular form, in Figure #1.

FIGURE # I

PERCENT DISTRIBUTION OF ADMISSIONS BY MENTAL DISORDER BY SELECTED TYPE OF MENTAL HEALTH FACILITIES. UNITED STATES, 1975



Source: Unpublished data, Division of Biometry and Epidemiology, NIMH

SOURCE AND INCIDENCE OF PROBLEM PER TYPE POPULATION

Figure #II shows the distribution of admissions to selected mental health facilities by race and age. For the White population the rates ranged from 936 per 100,000 in the age group under 18 years to a maximum of 2,436 per 100,000 in the age group 25-44. At 65 years and over there is a decline. The total rate for all other races 2,010 per 100,000 is 1.3 times, or 30 percent higher than that for whites (1,523 per 100,000), and is consistently higher than that for Whites in every age group, varying from 1.2 times the White rate in the 18-24 year age groups, 25-44 and 65 years and over. Note is made, too, that a glaringly inordinate number of Black mentally disordered males (80 percent) have been and are retained in correctional institutions while the White male, and particularly the White female, are rarely included in such institutions. As Figures III and IV illustrate the proportion of Black males in correctional or penal institutions approximate the proportion of White females in homes for the aged and dependent. North Carolina, this author's state, has the dubious honor of having the highest number of persons on death row to date of which 96 percent are Black. Blacks, on the other hand, constitute about 26 percent of the State's population.

Under any semblance of equality and fairness, one would not expect such results. To be certain, these results are not merely random errors or chance propositions, but clearly represent a carefully planned orchestration of the political system. For the groups and individuals targeted, the results are devastating in the sense these persons are left hopeless and powerless with eroded expectations and destroyed motivations that serve as Disincentives. With no incentive or motivation for change or improvement, feelings of no power and hopelessness become accelerated thus perpetuating the cycle. It is the opinion of many persons equipped to interpret the Black/mental health relationship that mental deterioration, the refusal to "get well," and death are the inevitable results of this cycle. Evidence of this rests with the fact that the life expectancy of Black males in the United States is 9.1 years less than his White male counterpart and 7.3 years less for the Black female than for the White female.

REHABILITATION AND MENTAL ILLNESS

The focus of the public vocational rehabilitation program, which was legislatively initiated in 1920, was on retraining eligible citizens who were injured in industry or otherwise. Each subsequent legislation has served to provide needed expansions of the program through budget increases and extending the definition of disablement to include a broader segment of the population. The inclusion of mentally disordered persons is an example of the program's expansion. Accordingly, substantial amounts of funds are channelled to rehabilitation agencies, facilities, etc. each year to provide rehabilitation services to affected citizens.

While rehabilitation mandates for services have been in place for a number of years, one wonders, based upon the extensiveness of the problem as previously discussed, how effective has rehabilitation been in addressing the problem.

FIGURE # II

Admission rates [a/] per 100,000 population [b/] by race and age, selected mental health facilities, [c/] United States 1975

Age	Total all races	White	All other races	Ratio of all other races to white rate
Total-all ages	1587.0	1523.4	2009.8	1.3
Under 18....	988.6	936.2	1253.4	1.3
18-14.....	2224.4	2159.1	2623.4	1.2
25-44.....	2569.1	2436.0	3494.0	1.4
45-64.....	1363.8	1339.7	1573.1	1.2
65+.....	721.5	696.0	977.9	1.4

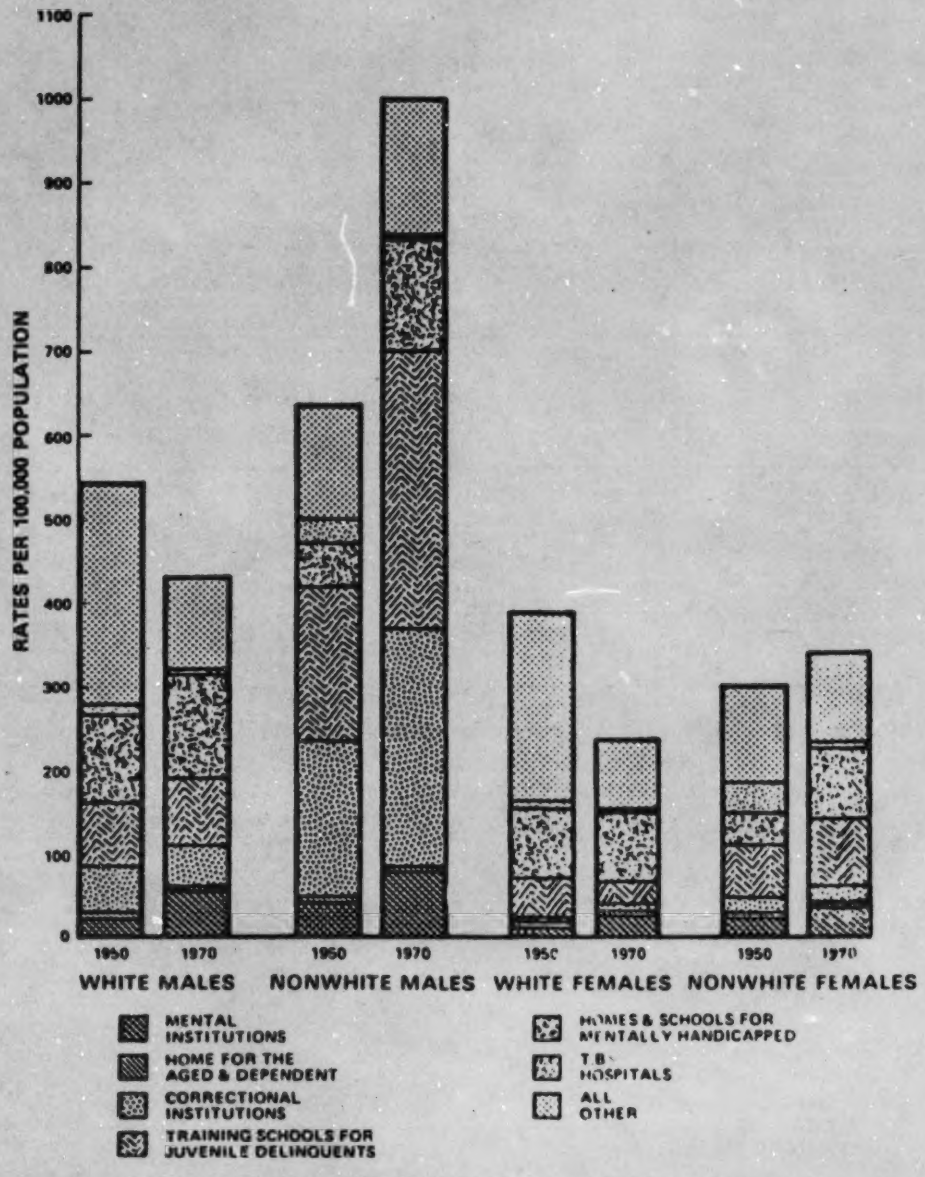
a/ Discharge rates from non-Federal general hospital inpatient units.

b/ Population estimates used as denominators for rate computations are from the Current Population Reports of the Bureau of the Census, Series P-25, No. 614.

c/ Excludes VA psychiatric services, residential treatment centers for emotionally disturbed children and day/night services.

FIGURE # III

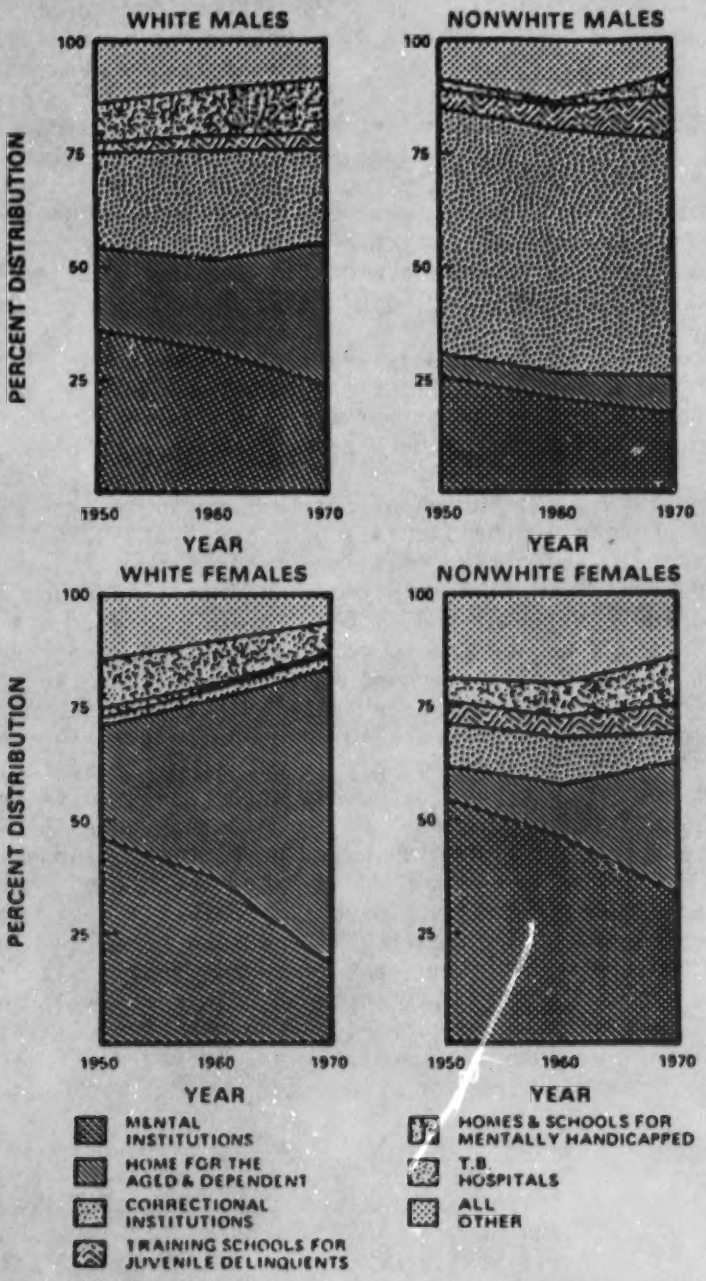
DISTRIBUTION OF PERSONS IN INSTITUTIONS PER 100,000 POPULATION BY TYPE OF INSTITUTION, BY SEX AND COLOR, AGE UNDER 20 YEARS, UNITED STATES, 1950 AND 1970



SOURCE: U.S. BUREAU OF THE CENSUS, PERSONS IN INSTITUTIONS, 1950 & 1970

FIGURE # IV

PERCENT DISTRIBUTION OF PERSONS IN INSTITUTIONS BY TYPE OF INSTITUTION, BY SEX AND COLOR, UNITED STATES, 1950, 1960, AND 1970



SOURCE: U.S. BUREAU OF THE CENSUS PERSONS IN INSTITUTIONS 1950 1960 & 1970

A recent Rehabilitation Services Administration (RSA) report provides some limited, but useful information on the subject (1978). A total of 287,441 clients diagnosed as mentally ill were referred to and seen by vocational rehabilitation offices throughout the country. Of this number, 62,927 patients or 22 percent failed (sic) or were not rehabilitated, 146,334 or 50 percent, were not accepted for services, and finally, 78,180, or 27 percent were actually successfully rehabilitated. Information for minority persons is not available. However, the trend has been that the success rates for Blacks and other minorities is about half that of Whites. The President's Commission on Mental Health sustains this point: "The chronically mentally disabled are a minority within minorities. They are the most stigmatized of the mentally ill. They are politically and economically powerless and rarely speak for themselves. Their stigma is multiplied since disproportionate numbers among them are people who are also elderly, poor, or members of racial or ethnic minority groups. They are the totally disenfranchised among us (Platman, 1978, p. 362.)."

This fact complicates an already existing problem in that three out of every four persons reporting for rehabilitation, a major source of aid for the mentally ill, are not rehabilitated or not accepted for services (R-300, 1978). For Blacks and other minorities, the picture is even more bleak.

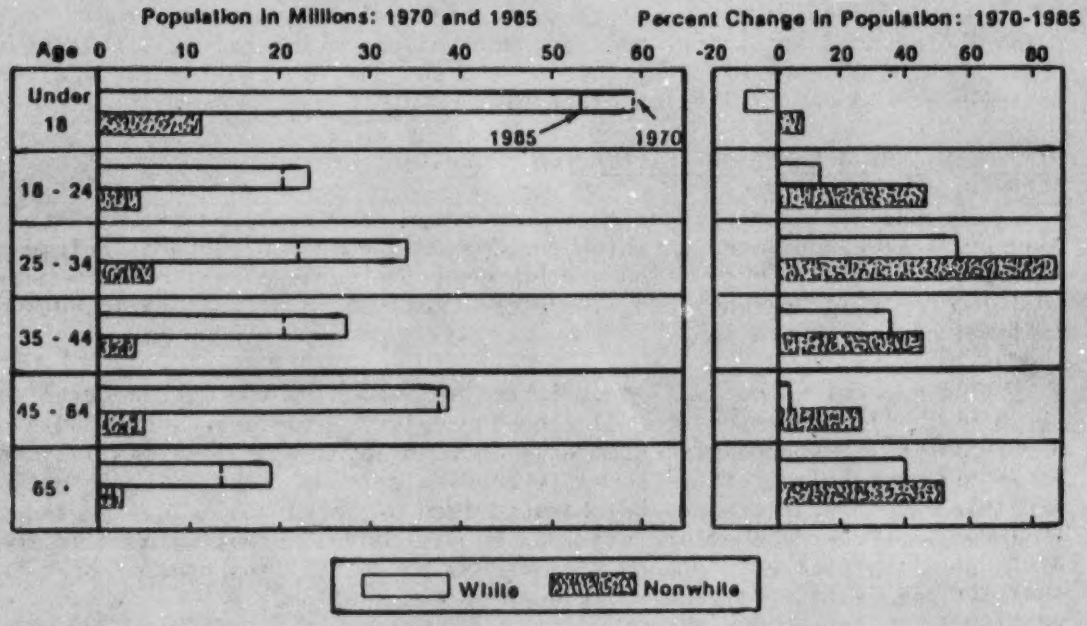
Further, the 1970 U. S. Bureau of the Census, see Figure V, shows some marked projected changes in the population by the year 1985. The population will have increased to about 234.1 million people, about 15.2 percent greater than in 1970 (203.2 million). The increase will be 13 percent for Whites (from 177.7 million to 200.5 million) and 32 percent for non-Whites (from 25.5 to 33.5 million). Non-Whites are expected to constitute about 14 percent of the population in 1985, as compared to 13 percent in 1970. The relative increases expected in the size of each group of the non-White population range from 87 percent increase in the age group 25-34 years to seven percent in the age group under 15 years. These increases are considerably in excess of those in the White population which range from 56 percent in the age group 25-34 to 13 percent in the age group 45-64 years. The number of White children under 15 will decrease by nine percent. Of particular importance is the fact that large increases will be occurring in age groups known from past experience to be characterized by consistently high admission rates to psychiatric facilities, correctional institutions, training schools for juvenile delinquents, homes for the aged and dependent, and homes and schools for the mentally handicapped. It is clear, then, that the burden of effectively treating mental disorders will be escalating, particularly for Blacks for whom current psychotechnology be brought on line to deal with the expanding numbers of mentally disordered persons in general and Blacks and other minorities in particular.

PROGRAMS AND RELATED TREATMENT SERVICES

The ineffectiveness of conventional psychotherapeutic strategies have been fully documented (Strupp and Beggin, 1969; Brinson, 1970; Carkhuff and Berenson, 1967). For minorities and Blacks, there have been a host of attempts to explain their general unresponsiveness to such programs. Some contend that the failure rates for Blacks are part of a grand, general plan to sustain and expand world domination of Whites over Blacks who constitute three-fourths of the world's

FIGURE V

Population U.S. 1970 and 1985 (estimated) and Percent Change 1970-1985 by Age and Color



Source: 1970-U.S. Bureau of the Census, U.S. Census Population, 1970, General Population Characteristics, PC(1)-131, Table 52.

1985-U.S. Bureau of the Census, Current Population Reports, Series P-25, No. 601, Table 8 (Series II Projection which assumes an average of 2.1 lifetime births per woman).

population (Fuller, 1969). Psychotechnology programs for Blacks would serve, according to exponents of this view, the interest of domination of Whites, (a world minority) over Blacks, (a world majority). Welsling (1970) seems to support this basic notion in attempting to show that Whites are compelled toward aggression, owing to their genetic deficiency state to produce skin pigments of melanin which are responsible for all skin coloration.

Banks (1967) found that when Black patients and Black therapists are matched by race the patients are more likely to return for services than when the two groups are crossed. Mizelle (1976) and Brinson (1976) discuss elsewhere the implications of cultural diversity in limiting the effectiveness of human service delivery systems such as psychotherapy and other human resource programs.

More generally, a number of psychotherapeutic theoriticians have offered frameworks upon which effective mental health intervention services should or could be built, i. e., rationale, learning theory, psychoanalytic, existential and perceptual-phenomenological approaches.

None of these programs or theories speak directly to the single factor that contributes most to patient success, motivation or incentive. It is thus important, in the absence of literature on the subject, to examine this factor in the context of the rehabilitation process.

DISINCENTIVES AND THE REHABILITATION PROCESS

The basis of patient growth in any human services program, particularly a service like rehabilitation which requires his complete cooperation and participation, begins with motivation. Otherwise, the goals of neither the patient nor the program will be realized. Therefore, motivation or patient incentive is the essence of rehabilitation.

The concept of motivation or incentive, which is the more general term that is more easily understood in relation to applied (non-laboratory) human settings, is a continuing source of controversy in both lay and professional circles. However, among scholars, there seems to be wide agreement on the basic notion that all motivated behaviors may be characterized as being goal-directed and purposive. Further, motivated behavior is guided by its consequences, related to some end point, and carried out in such a manner as to satisfy the present or future ecological requirements of the individual or the species.

Lay persons, on the other hand, see motivation or incentives in terms of hypothesized states such as hunger, thirst, curiosity, fear, aggression, instinct, need, drive, etc. Such terms are loose descriptive concepts that refer to inferred general states rather than concrete processes that can be readily reproduced and measured (Altman, 1966).

In studying motivation from a biobehavioral view, Wong (1976) limits his examination to consumatory acts such as feeding, drinking, mating, sleeping, dreaming, stimulus-seeking and attacking, etc. which is consonant with Denny and Ratner's (1970) position that defines motivated behavior as molar acts that regularly consummate or terminate a recurring behavior sequence.

While it may be interesting to study motivation or incentives in terms of certain effects (neural, endocrine-hormonal deprivation) on certain consummatory behaviors (feeding, drinking, sleeping, etc.) the application of the obtained results to human problems is often too tentative to be of any substantive value except in restricted circumstances.

Another major difficulty that limits the application utility of such laboratory-based information is that it is often based upon genetic or natural assumptions, i. e., the organism's behavior potentials are relatively fixed by reason of historical or hereditary conditions.

What seems to be sorely needed, especially for purposes of manipulating motivation or incentives in relation to rehabilitation, is information based upon nurture or learning concepts which would, when necessary, permit change in one's motivation level via some psychotechnology strategy such as psychotherapy, teaching motivation to patients or providing them with certain experiences that would improve their motivation level.

The early works of Heider (1958) and subsequently that of Rotter (1966) provide a combination of propositions that, with modification, could be particularly relevant to the goals of reducing patient disincentives and enhancing the rehabilitation process.

EXPECTANCY AS A REHABILITATION INCENTIVE

It was Heider's basic belief that individual incentive is manifested by "trying" behaviors which are determined by "want" on the one hand and "can" on the other. He believed that a person will try (incentive manifestation) if he wants to accomplish a goal or if he can accomplish a goal. Conversely, there is no trying unless it is accompanied by can or want.

His model drew wide attacks from a number of critics who pointed to many instances in which "trying" behaviors would be initiated even though the conditions of can or want did not prevail. Accordingly, Heider ably revised the model to show that trying behaviors were mediated by a powerful and highly applicable phenomenon, expectancy. If can and want conditions are met and trying behaviors do not follow, it is assumed that the expectancy element is missing. Further, and perhaps most importantly, expectancy can generate trying behaviors even in the absence of can and want.

The soliloquy for the rehabilitation purposes, is that mentally ill patients, who either perceive themselves as being unable (cannot) to be rehabilitated or do not desire (want) to be rehabilitated may, nonetheless, be successfully rehabilitated as they will submit themselves (trying) to the rehabilitation process. This makes expectancy a powerful and potentially useful factor, and it has wider implications as well. Perhaps the patient's circumstances preceding, during, and following his rehabilitation involvement destroys expectancy by requiring dependency upon test scores, experts such as doctors, counselors. This could well mean that the current rehabilitation process could, by its requirements, be working against itself by reducing expectancy and thus reducing patient incentives.

Expectancy, it seems, is contingent upon the extent of control (perceived or otherwise) the person has over his growth and ultimate destiny. Rotter's Internal-External*Locus of Control notion, which speaks directly to the orientation of control, seems pertinent. Those with an internal locus of control will theoretically maintain expectancy while those with an external locus of control will instead embrace chance, luck, powerful others which is an "other" dependency, self-limiting and often demonstrably self-defeating penchant.

Hatley, (1978), Evans (1978), and Smith (1979) have demonstrated the application value of the I/E* via controlled experimentation to a wide variety of human services needs. Specifically they confirmed that I/E*orientations can be acquired through a teaching/learning process, i.e., internals can be taught to be external, externals can be taught to become internals, etc. They also confirmed that persons who move toward an external orientation will manifest an increased amount of "trying" (incentive) behaviors and will also reach a comparatively higher achievement performance.

A PSYCHO-SYSTEMIC APPROACH TO FOSTERING PATIENT INCENTIVES IN REHABILITATION

This writer takes the position that the matter of motivation in general and incentives in particular is clearly a learned phenomenon. Further, disincentives can be and are learned, although perhaps unintentionally. From a systemic perspective, it follows that environmental contingencies could be arranged in ways that "teach" disincentives by, for example, assigning to patients unintelligible and unfamiliar terms (schizophrenia, passive-aggressive, etc.). The more severe the label, the less the patient needs to do (positive reinforcement) to improve in that he perceives his case as others do, hopeless. Further, with labels like these, the patient's feelings of helplessness and eternal dismay are inescapable.

Also, patients come to realize early in the rehabilitation process that evidence of personal control or personal incentive can risk a severe diagnosis and perhaps jeopardize a pleasant relationship with service providers. Consequently, he is likely to follow the rewards and submit to the system without question or without seeking clarification. The system, again, becomes a disincentive. In rehabilitation, the client has virtually little room for negotiation regarding either his eligibility determination (which is determined by someone else) or his vocational goals (which the patient likely feels is determined by others). He does not select his doctors, psychologists, counselors, etc. as all of these persons are screened and marketed by someone other than the patients. <u>It's all in the Manual!</u> The patient is thus left with virtually no responsibility for his general welfare or rehabilitation. Essentially, the mentally ill patient is deprived of opportunities for reinforcement to sustain appropriate incentive. Thus he fails (sic), as three out of four patients did in the 1978 RSA reports (R-300, 1978).

What is needed therefore is some rearrangement of the psycho-political processes that would provide individuals with more actual control, by exercising free choice, in their own survival. Perhaps, in our efforts to be fair, we have simply established policies and procedures which are used as excuses for fairness. Patient's rights, licensure requirements for professionals, affirmative

*Internal-External Locus of Control

action, etc. are examples. Our political system compels conformity, dependency, acceptance, reliance upon change, luck, powerful others (External Locus of Control) which are key elements in the formation of disincentives. Mental health patients simply reflect orientations evolving from previous interactions with the larger society.

Following this logic, it seems that the rehabilitation process should be systematically rearranged to avoid these disincentives and to implement such changes that would foster patient independency, an internal orientation rather than an external one; and finally, an improved incentive to move towards one's own rehabilitation.

Proposed changes in rehabilitation practices and procedures that would possibly lead to these objectives would be to:

1. Require patients, as perhaps a condition of their receiving services, to know and understand principal rules and regulations affecting them. If these are too difficult to be understood, they should be eliminated (not the patients).

2. Allow and encourage patients to make full use of the free enterprise system (emphasis on free) in relation to contracting their own diagnosticians, purchasing and negotiating with vendors, etc. Assuredly, with this process, the quality of services would increase and the cost would decrease.

3. Provide patients with a budget within which their total rehabilitation must stay. Issue credit card-type instruments for their easy use and accurate recording of expenditures. Money saved would revert directly to the patient for his personal use, whereas over-expenditures would have to be refunded by the patient when his employment begins.

4. Lessen the distance between service providers and their recipients, particularly that perceived by the patient. Perhaps an advocacy role rather than an advisory one, which would diminish traces of the "doctor-patient relationship," would be a strategic starting point.

SUMMARY AND CONCLUSION

This paper attempted to outline the scope of the problem of mental illness in the United States. It stressed the difficulty that minorities, i.e. Black Americans, have in coping with the disease. Much of this difficulty, however, lies in the psycho-political system, of which rehabilitation and related mental health systems are part and parcel. The claim was made, with supporting documentation, that such systems actually destroyed the most important factor that contributed to patient success--incentive.

Recommendations were offered, relative to making such systemic changes in policies and regulations, that would avoid the "accidental" reduction of patient incentives.

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EXCERPTS OF REVIEWS AND COMMENTS

The following are excerpts of reviews, comments and questions raised by the Switzer Fellows. These are presented to further stimulate thinking as well as action as it relates to the content of the paper by Dr. Brinson.

"Several interesting research projects could result from the author's ideas regarding placing more control into the hands of clients. Obviously there are levels of control which correspond to ability to cope with basic psychosocial functions. These could be teased out of the literature and tested. In addition, clients could be queried regarding their level of satisfaction with the system as they acquire more responsibility for their destiny.

After testing the above hypotheses and others, it could be determined if policy changes were required.

The author implies that rehabilitated individuals are more motivated and more internally controlled. Research might be conducted which compares motivation levels of persons refused treatment, those successfully rehabilitated and those who are unsuccessful with the system. Of particular interest will be the psychological dimension of locus of control.

The author also points to a need for persons in authority who are less bound by convention. He realizes the system will not tolerate these persons, but believes they are better for the client. This issue needs to be discussed in the context of roles and responsibilities of the rehabilitation agent. Creative management is not easy to achieve in a constrained environment.

The credit card concept is in keeping with our belief in the individual and gives action to the notion of free enterprise. Theoretically, those services would flourish which are needed and which provide the kind of service clients want to access. New legislation might consider a system which places more responsibility with the client to spend within a limited budget based on severity of disability and demonstrated capacity to plan."

-- Robert J. Grantham, Ph.D.

"Dr. Brinson's paper focuses importantly on the psychopolitical problems which Black Americans face in receiving effective mental health treatment in the United States. He highlights significant research which points to motivation, expectancy and cultural compatibility between therapist and patient as factors effecting treatment outcome. The paper also cites significant research which implies, although broadly, the need for focus in the following areas:

1. Service Delivery -- In order to increase the effectiveness of service to minority populations, Federal funding agencies (e.g. NIMH, NIHR, etc.) should

explore ways of encouraging and supporting the development of community based treatment efforts by Black professionals (and other minority professionals) serving members of their own ethnic groups.

2. Research -- Existing models of culturally specific rehabilitation and treatment services for the mentally ill among minority professionals should be given increased research capability by NIMH and NIHR. In this way, wider knowledge of the significance of culture in treatment services delivery may be gained. Research methodology should emphasize "soft" research methods which can best reflect the complexity of human dynamics.

3. Training -- Research and Training Institutes to be jointly developed by NIMH and NIHR should seek input from Black professionals (and other minorities) who have had significant effective experience in treating the mentally ill among minorities in outpatient as well as inpatient settings. It is important to include those with experience in voluntary as well as public settings to achieve wide perspective."

-- Doris W. Dennard, M.S.W., C.S.W.

"Patients must be given the opportunity to make choices for themselves about treatment, work, etc. Physicians, family, friends, medicine, hospitalization, etc. have done so much for the patient - now what is the patient going to do for himself. This will take a program of reeducation - of learning to make decisions, of making mistakes, of failing, of trying, of getting rid of the old habit of "I can't" and replacing it with "I can, but I will have to bear some discomfort", until some new habits of acting, reacting, thinking are established.

Perhaps some research needs to be undertaken to see how effective it would be to give patients the right to decide some things for themselves about treatment, etc. When given a choice or right to decide, are they then developing the incentive, motivation for acceptance of responsibility and change for themselves."

-- Nancy Downes

SUMMARY OF RECOMMENDATIONS

The following is the summary of recommendations and implications for action as developed by the Switzer Fellows for the topic of the second paper (The Recorder was Steven M. Fishbein):

POLICY AND PROGRAM DEVELOPMENT

1. It is recommended that program models include social and functional evaluation methodology based on specific, concrete measurement techniques.

2. There are many examples of financial and program oriented disincentives to the rehabilitation process. A consumer oriented review of fiscal incentives and disincentives in rehabilitation is needed.

3. Long-term financial support (as illustrated by SSI, SSDI) needs to become consistent with long-term rehabilitation goals so that the client is allowed to become more functional and gain the highest level of independence possible, rather than remain dysfunctional in order to receive financial assistance.

4. Recognizing that many studies and commissions have clearly identified a bias in the delivery of rehabilitative services to various ethnic and cultural groups, a major thrust towards the development of the state of the art in this area is needed in terms of ethnic and culturally acceptable programming, i.e. for Hispanics, Blacks, elderly and others.

RESEARCH

1. It is recommended that further development of knowledge, methods and techniques in dealing with issues such as locus of control and learned helplessness as illustrated by Brinson, 1970, Evans, 1979 and Hatley, 1979 (referenced in Dr. Brinson's paper) be undertaken.

SERVICE DELIVERY

1. It is crucial that rehabilitation retain and enhance its view of mental illness as concrete difficulties in functioning (competency) rather than as a psychopathological process, and that comprehensive, concrete services based on needed employment and community skills continue to expand.

2. It is recommended that administrative and supervisory personnel in rehabilitation and mental health recognize the importance of the community and its resources in working with the mentally ill, and that they utilize an increasing amount of their time and expertise in the development of these community resources.

3. Recognizing the priority of community organization and resource development, administrative and supervisory personnel in rehabilitation and mental health need to strongly support counselors in their efforts of community resource development and services, providing a functional or competency-based approach.

4. It is recommended that consumers and self-help groups have active participation in the development, implementation and accountability, in terms of monitoring outcomes of agencies providing services to the mentally ill person.

TRAINING OF PERSONNEL

1. In following the trends towards a competency (functional) model of rehabilitation, it is recommended that rehabilitation and mental health counselor training programs give priority to the development of community resources and organizational skills as well as other skills which will assist the counselor in facilitating concrete, functional services to the mentally ill client.

2. To assure that college, university and alternative training programs achieve the desired outcomes(to train new rehabilitation and mental health personnel in up-to-date and useable skills, techniques and information), it is recommended that these training programs be evaluated by employers who are hiring their graduates and by consumers who are utilizing the graduates' services.

3. It is recommended that as the state-of-the-art of acceptable ethnic and cultural programming and service delivery improves, that counselor training programs incorporate and utilize this information in their course of study.

4. It is further recommended that agencies that are receiving training funds, as part of the fiscal solicitation and utilization process, develop written plans to demonstrate how they intend to introduce the concept of ethnic and culturally oriented programming into their curricula.

5. In recognition of the success and creativity with which various agencies are working with the mentally ill, it is recommended that there be an expanded effort for the continued development and implementation of training programs of rehabilitation and mental health personnel by these agencies as illustrated by the Fountain House training program.

6. It is recommended that Service agencies providing staff training enhance their efforts by having their training staff provide follow-up technical assistance and on-site visits to trainees after completion of the formal training program.

7. In order to adequately train rehabilitation and mental health students in currently effective techniques and information, it is recommended that Rehabilitation and mental health agencies who fund college and university training programs require those programs to develop curriculum review committees made up of consumers and direct service professionals. These committees could provide input on currently effective techniques, methods and information to be utilized in course content and selection. It is further recommended that granting agencies require the above input as part of the funding process.

8. Consumer groups should be provided with leadership training to facilitate their active involvement in the development, implementation and accountability process in rehabilitation.

9. It is also recommended that all training recommendations in these proceedings be immediately forwarded to the chairpersons of rehabilitation counselor training programs for their review, stimulation and consideration as we prepare to serve the mentally ill in the 1980's.

CHAPTER THREE

STRATEGIES FOR COORDINATING SERVICES IN THE REHABILITATION OF THE MENTALLY ILL

AUTHOR: BROCKMAN SCHUMACHER, Ph.D.

SUMMARY OF PAPER

Dr. Schumacher gives a comprehensive review of significant studies in the coordination of services for the mentally ill and from this basis goes on to make excellent suggestions for the coordination of services during the 1980's. As his review of the literature in this area indicates, effective programs for the chronically, mentally ill do result when multiple resources are used. He also points out that studies indicate that ongoing, continuing contact is always needed and that rehabilitation planning can expect "interruptions, rehospitalizations or occasional exacerbation of the symptoms." His recommendation for the 1980's are very sound dealing with the need for client advocacy, that services be individually tailored, that a consortium of agencies be used, that support systems be explored and, where total comprehensive systems cannot be organized, advocacy models for the client are essential.

-- Robert D. Ray

The purpose of this paper is to review developments in the coordination of services for the mentally ill and to derive trends and proposals for the 1980s. Review of the reports of agencies, practitioners and researchers indicates that coordination and linkages of a great variety of services have been conducted over the past decade. A considerable number of models have emerged. Transitional living, comprehensive centers, volunteer participation and advocacy are examples. Though effective in varying degrees, few approaches have become national practices or thrusts. They remain the efforts of specific public, private and voluntary groups. Also, a question that is always before us is to what degree the severely mentally ill are being served. Some background to these two problems should first be mentioned.

As early as 1962, President Kennedy instructed government agencies to develop strategies recommended by his Joint Commission on Mental Illness and Health. The Joint Commission had said, "It is important that rehabilitation be regarded as a part of a comprehensive program of patient services in which each and every member of the mental health team has a part to play". Mary Switzer, in reply, said that rehabilitation of the psychiatrically disabled would be a priority for the 1960s. She called for the "concentration of more of our talents and efforts on the rehabilitation of those who have been disabled by mental illness."

By 1963, President Kennedy had called for a fifty percent or more reduction in the number of patients in mental hospitals within a decade. In his message to Congress that year, he proposed more than simple restoration. "The objective was to keep the mentally disabled in the community and restore and revitalize their lives through better mental health programs and strengthened educational and rehabilitation services." This led to a flurry of activity, particularly in the development of services and of research and demonstration projects. The focus was toward shifting the emphasis on care from state mental hospitals to community facilities. Training of all personnel to work with the psychiatrically disabled was undertaken with the understanding that teamwork among many disciplines would be the only way the task would be accomplished.

The 1968 amendments to the Rehabilitation Act gave specific emphasis to follow-along and post-employment services. Now, most recently in 1977, President Carter established a commission to review the nation's mental health needs. The purpose of the commission was to propose strategies for prevention, improving public understanding, community support and a responsive service system. The report of this commission took into account aspects of adjustment involved in the successful return of the psychiatric patient to the community. The commission proposed that mental health services work more closely with each other and with social support systems that strengthen neighborhoods and communities to respond to the mentally ill. It proposed a "national priority" to meet the needs of the chronically mentally ill. New concerns such as advocacy, coordination of all hospital and community based programs, legal and ethical responsibilities and prevention had emerged during the last decade. Also, in the 1970s, the General Accounting Office called for more emphasis on deinstitutionalization. President Carter's commission (1977) cited more dramatic statistics than the 1970 census. About 20 to 32 million Americans will need some kind of mental care. Of these, at least two million have schizophrenia and an equal number have disabling depressive disorders. About 30% of all hospital beds are still occupied by those with mental health problems. Although the Kennedy goals were partially achieved, severe problems remain.

The total number of the severely disordered remained at about the same level although the state mental hospital population for this group was reduced from 550,000 to 200,000 by 1975. Although the focus of treatment and rehabilitation has been shifted from the hospital to the community, the number of rehabilitants among the most severely disabled has not increased decisively in the past ten years. The period has been characterized by dramatic legislative and funding efforts that have generated community mental health clinics, improved hospital programs and a multi-disciplinary capability of dealing with the chronic clients' return to the community. Today, the problem is not so much the development of new techniques and methods, but rather the coordination of multiple programs towards successful rehabilitation.

Sands and Radin (1978) have pointed out that technology had to grow to the point where the severely mentally handicapped could feasibly benefit. It is first useful to isolate and tease out of the experience of the 1970s, lessons from the variety of approaches, techniques and research that have been carried out. What follows is an effort to review the information and approaches of the past decade and to identify both needs and implications for effective coordination of services for the mentally ill.

In a 1969 article, McDonald (1969) placed emphasis upon psychiatric rehabilitation as focusing on assets rather than liabilities. Rehabilitation was viewed as being an integral part of community psychiatry and as having an even greater contribution in the future. The author concluded that the degree to which the psychiatric patient will benefit from services will depend upon the coordination and cooperation of persons and agencies providing these services. Problems of the long term adjustment of the severely mentally handicapped will remain with us in the 1980s. Coordination of services for this group will be the main focus of this paper. We must first ask what are findings so far for this group in terms of readmission and discharge.

One of the largest and most impressive studies was conducted by Friedman, Maring and Henko (1966). These investigators conducted a follow-up study of 1,037 patients admitted to the Cleveland Psychiatric Institute. Release rates and relapse were observed over a five-year period. They concluded that the problem of chronicity has given way to intermittent "patienthood" as a mental hospital career pattern. Implications for program evaluation and planning include continued evaluation of the hospitalization - non-hospitalization dimension and analysis of the most appropriate post-discharge period for follow-up studies of outcome. They also suggested a need for changes in staffing pattern as a reflection of the special needs of the intermittently hospitalized. Intermittent hospitalization and a need for perhaps brief treatment throughout a long term adjustment period is a reality that must now be faced.

Attitudes of former patients about their own community adjustment were investigated by Michaux and Michaux (1968). They conducted monthly interviews with behavioral questionnaire assessment in a one-year study of post hospital adjustment. Their results indicated that most former patients felt that follow-up contact on a monthly basis had been helpful. The authors also believed that ex-patients who dropped out of a one-month follow-up study may have done so to repudiate their own roles as psychiatric patients and to forget their hsopitalization. This study may hint that a gradual dissociation from hospital or therapeutic environment is important in successful post hospital adjustment. Non-hospital personnel, especially volunteers, are implied.

Strum and Lipton (1967) gathered data on 87 newly admitted patients to a state mental hospital. Predictors for readmission were found to be related to full-time employment after hospitalization, pre-hospital preference for voluntary social participation and less than six months employment during the last five pre-hospital years. Patients who had previously been employed in technological work also tended to have full time employment. Struhm suggested that although this specific predictor may tend to be overlooked in formulating predictive studies, it seems useful in estimating individual rehabilitation potential.

Arthur and Ellsworth (1968) report a study of two groups of twenty-three released schizophrenic patients differentiated on the basis of readmission to the mental hospital. They found that only three of their 19 demographic variables and one attitude variable were accurate in discriminating readmissions. These were a large number of hospital releases during the past three years, a large number of prior hospitalizations and active participation of the former patient

in effecting hospitalization. The authors propose that hospital type variables will remain as a predictor of hospitalization and again point to the need of long term and continuous follow-up.

At this point, we can say that intermittent hospitalization, the degree of post hospital contact with mental health personnel and a variable post discharge level of functioning are characteristics of the chronically mentally ill. Other studies to be cited have identified a great number of factors contributing to rehospitalization and longer term adjustment.

Spiegel and Spiegel (1969) examined the factors that make hospitalization seem necessary to the patients themselves. They reviewed both hospital and community influences. Data were collected from 100 consecutively readmitted psychiatric patients. "Nervousness" was cited by 42 percent as a prime reason for returning to the hospital, along with multiple reasons, such as physical health, depression, inability to find a job, financial difficulties and strange and frightening thoughts. Fewer than one-half were eager to return and try again in the community. A major recurring theme was concern by the patient with how they would use their time when they leave the hospital. The authors suggest that a strong community support through help in finding jobs, sheltered workshops or other protected settings is needed.

Bachman (1971) described the experience of a patient leaving the security of hospital care and entering the world outside of the hospital. She relates how threatening and anxiety producing it was to carry out interpersonal relations and perform all of the trivial things necessary for day-to-day existence. Of special interest is her implication that the opportunity for intense social involvement offered in a well organized therapeutic community may create a new set of problems for the patient, because newly acquired social skills and experience may lead to the false belief that it is relatively easy to form and skillfully manage a wide variety of human relations.

Talbot (1974) studied the reasons for high rates of readmission to a state psychiatric hospital, as well as the means of preventing this hospitalization. Return patients were assigned to research teams to assess the reasons for readmission. It was determined that 84 out of 100 readmissions could have been prevented had support services existed. Of a number of suggestions for possible preventive measures, the further increased involvement of the patient's family and use of community resources before and after discharge were found to be important. Also, the continued administration of psychopharmacological agents were proposed. The listing goes on: more vocational rehabilitation, structured living situations, family therapy, home visits, crisis intervention, day center and day hospital, social clubs and halfway houses. As late as 1975, each one of these approaches was still recommended by researchers.

A study that dramatically emphasized the importance of severity was conducted by Schlamp and Raymond (1971). These authors report findings on more than 300 mentally ill patients referred for vocational rehabilitation services. This group was interviewed two years after case closure. They discovered that although all clients had been previously hospitalized, those who were first referred while hospitalized made a better adjustment relative to their anti-

cipated adjustment than those clients referred after release to the community. Fifty-four percent of the clients rehabilitated were still employed at follow-up. Employed clients had been given more services, had received a greater amount of support from family and employer and had better past employment and hospitalization histories. The effects of long term unemployment or hospitalization was the withdrawal of support and assistance from employers, families and friends. The authors especially noted that when the effect of mental illness is severe, predictions of the person's level of employment, based on prior employment, are seldom accurate.

Loeb, Abraham and Rutman (1969) investigated the possibility that diagnostic label and severity of illness may influence vocational, social and psychiatric judgments about ex-mental patients. They administered questionnaires to 120 vocational rehabilitation counselors and 120 businessmen - professionals where the individual rated biographical sketches in which diagnostic labelling and severity of illness were varied. Their results indicated that diagnostic labels did not influence attitudes, but that severity of the psychiatric condition did have an effect. The two groups did not differ significantly in their ratings contrary to the expectation that judgmental differences would occur as a result of the "sophistication" and "professional involvement" of the counselors. The ineffectiveness of the diagnostic labels was explained by the authors as being under-emphasized or not comprehended in the case histories, or that the effects of the severity of the illness or degree of abnormality might have been so strong as to override any labelling effect. This condition can still apply and often leads to the disappointing statistics in rehabilitation of the more severely mentally handicapped.

A study that dramatically indicates the need to change professional attitudes toward the mentally ill and similar populations is one by Wicas and Carluccio (1971). The authors investigated counselor attitudes toward three handicapped groups: the culturally deprived Black, the ex-mental patient and the ex-convict. Fifty-four rehabilitation counselors and 58 school counselors responded to a forced choice questionnaire involving preferences among clients in various situations. Results indicated that the culturally deprived Black is the most acceptable by the counselor, and by society, as the counselor perceived it. The ex-mental patient is seen as least acceptable for positions dealing with trust and responsibility, least in control of his fate and least able to be helped by community programs. The results indicated that awareness of biases and counselor attitudes may be an important factor in working effectively with handicapped clients. The authors suggest pre-service and in-service training programs, including the use of encounter and confrontation groups in the training of counselors.

Employer attitudes may also not have changed significantly over the past decade. Hartlage and Roland (1970) measured employer attitudes toward those with former mental problems, mental retardation and major amputations. Ninety-two employers, each employing 50 or more workers, were mailed a survey letter asking their cooperation in filling out a questionnaire - 73 questionnaires were returned. The questionnaires asked each employer to rate the extent to which they might expect problems from the three handicapped groups in seven work-related behaviors. These behaviors included need for supervision,

physical work tolerance, reliability and tolerance of pressure. Although amputees were seen as "average" or "better than average" employment risks, the retarded and formerly emotionally disabled were viewed as "below average" and "poor" employment risks. Areas of greatest concern to employers were that the formerly emotionally disturbed would have trouble tolerating work pressure.

To summarize the above, it can be said that the problem of readmission for the long-term chronic mentally ill has remained through the mid 1970s. Severity of disability cannot be discounted in considering the prospect of rehospitalization. The long-term former patient often has a history of rehospitalization with several investigators proposing protected settings as a solution. By the mid-1970s the need for continued support services was recognized as a solution for extending productive periods outside of the hospital. The attitudes of professionals, employers and the community remained negative for the long-term chronic mentally ill, in spite of the progress in the past two decades in the development of community understanding for the mentally ill. This paper will now review specific approaches and techniques used over the past ten or fifteen years in areas of preparation for discharge, support, aftercare systems and rehabilitation. This will be a sampling of models that have been found to contribute to rehabilitation with implication for their combination.

The psychiatric community has moved along the same direction as rehabilitation in its concern for the chronic mentally ill patient. Marks, Test and Stein (1973) proposed a rationale for what they called a "total in-community treatment model" for patients still symptomatic and in need of intensive treatment. The program emphasized strategies for patient acquisition of coping skills necessary to live in the community, no rehospitalization, working with families and significant others, individualized attention from staff, close working relations with community facilities and special efforts to prevent patients from dropping out of contact after discharge. They compared persons receiving a coordinated program to control groups. Results indicated no difference in symptomology or self-esteem after five months of coordinated treatment, but their experimental group was living and working in more autonomous situations. They concluded that it is possible to implement a program treating highly symptomatic patients in the community without alienating individuals or agencies in the community. Purvis and Miskimins (1970) proposed a community-based, structured follow-up program as a more effective alternative than improved hospital treatment programs. They suggested that even brief intermittent hospitalization fosters dependency and hinders rehabilitation. They proposed that individual and group approaches reduced recidivism and increased the patient's independence and adjustment.

Anthony and Buell (1973) found that former patients who attend aftercare clinics have a better chance of remaining out of the hospital than those who do not attend. No differences were found in post-hospital employment. They proposed that a discharge procedure allowing for smooth hospital-to-clinic transition and greater encouragement of former patients to attend clinics would be a step toward long-term post-hospital adjustment. It must be noted that no differences were found between employment for the groups who attended or did not attend aftercare. Here, we see an example of how the effective adjustment on the part of the discharged patient may not mean competitive employment.

In a provocative study, Nicholas (1967) related hospital status of long-term schizophrenic patients with observations made during rehabilitation. Follow-up data was collected from 66 former hospitalized chronic psychiatric patients and compared with hospital observations of behavior, work performance and leucotomy status. His results indicated that the successful patient showed less evidence of schizophrenic withdrawal, both at the beginning and at the end of the rehabilitation course. Unsuccessful rehabilitated persons became more handicapped as the process of rehabilitation progressed. Those patients having a previous leucotomy tended to have a poor post-hospital post-rehabilitation progress. Nicholas suggested that unless schizophrenic patients function at a sufficiently high level, they may not be able to meet the demands of a rehabilitation program. Here, we have a suggestion that the rehabilitation program alone may exacerbate symptoms.

Saenger (1970) reported changes in symptoms and functioning among adult patients treated in 24 psychiatric outpatient clinics and untreated patients seen for diagnosis and evaluation only one year after intake. The uneducated, those with limited self insight, those with low anxiety, those with a diagnosis of psychosis or personality disorder rather than neurosis, the unemployed and the unmarried were generally seen as having a poor prognosis. His results indicated that improvement rates were higher for the treatment group for those patients generally considered to have a poor prognosis. Among those with a good prognosis, the untreated tended to improve more often than the treated. Motivation for treatment was not seen as a valid predictor of change among the "treated." The author suggested that clinics may be well advised to devote more of their efforts toward poor treatment risk patients rather than those with good recovery. This study points to a selectivity which was occurring at the beginning of this decade and that may still effect rehabilitation. Of note is the observation that motivation was not a necessary predictor of response to counseling and psychotherapy.

Other models have been proposed in the past decade. Polak and Jones (1973) proposed treatment and rehabilitation strategems within a spectrum of semi-sheltered settings. These settings constituted what they called a "psychiatric non-hospital." The traditional model of the psychiatric hospital is seen as interfering with rehabilitation because the former patient is removed from his natural social environment and placed in the "irrational" social environment of the hospital. Instead, the authors propose intervention by way of mobile treatment teams that would work with both the illness of the patient and the social system disturbance. Such home treatment would utilize community resources, natural helpers and neighborhood indigenous nonprofessionals. The next step in this approach would be the "brief asylum," in which the patient would reside in an artificial replacement for the stable family system. The final step is separation and relocation of the patient.

The above studies suggest selectivity in aftercare clinics and recognition of the need for long-term contact. Rehabilitation programs alone may not be the long-term answer to the severely mentally ill.

A number of models for transitional living have emerged in the 1960s and 1970s. In an approach seldom used or conceptualized in rehabilitation, Cunningham, Botwinik, Dolson and Weikert (1970) tested the effectiveness of

successful adjustment of psychiatric discharges in the community by way of placement in private homes. "Poor risk" patients were selected and questionnaire results were taken. Results from the 111 cases were that 44 remained in the community for two years or longer, 48 remained from one to 11 months and 19 from 12 to 23 months. Factors associated with success were younger age and cumulative hospitalization. Widowed, single or married former patients were more successful than those separated or divorced. Patients who held jobs, attended day care centers and who were in referral to DVR remained in the community longer. The first month in community placement was the most critical for the entire sample.

Chien and Cole (1973) describe landlord-supervised cooperative apartments for the long-term mentally ill. This was a cooperative effort between state agencies and a concerned community to prevent the indefinite institution of long-term patients. A number of three-unit dwellings were utilized, in which the landlord, the former patient and some community residents lived in each apartment. Landlords applying to be patient supervisors were evaluated by staff before assignment. Under the care of the landlord, patients were responsible for routine chores and worked gradually toward self care and independent living. Supervision was given by a cooperative apartment team which consisted of a psychiatrist, social worker, occupational therapist and nurse. Patient-tenants were expected to engage in daytime activities consistent with their functional level. Eighty percent of the 186 patients in this program were successful in remaining in the community. Landlord ratings indicated an improvement in mental condition, housekeeping skills, personal hygiene, grooming, personal relationships and adjustment to community life. Another important benefit of this program was its low cost. Costs turned out to be lower than any other hospital or community facility. Community resistance was dealt with by way of the landlord participation in the program. The authors particularly recommend this approach to rehabilitation for urban inner city situations.

Sanders (1970) described a project in which task groups trained in decision making in the hospital are moved into the community in unit. Such a move maintains the group member with an established status and role within a social system that has demonstrated stability. The task group was formed and, while still in the hospital, was given problems that would occur in the community. Such problems were organization of a "lodge," maintaining themselves and caring for others, purchasing and preparing food, securing employment and bookkeeping. This pre-planning, as well as the research staff's feedback on the group's decisions, were thought to develop abilities that would transfer to community living. Although initially the project was coordinated by a psychologist, it was later demonstrated that interested and motivated lay persons could effectively coordinate the community lodge. During the three years of the lodge's operation, the men functioned as a group to meet their responsibilities and often in sometimes ingenious ways. At the end of three years, when hospital funding was phased out, the group made a successful transition to independence. Still operating as a group, it leased two houses in a middle class neighborhood and continued its group functions. When this group was compared with a matched control group, it was found that the lodge group was able to remain out of the hospital longer and assume employment more often. The lodge maintained but did not grossly affect behavior adjustment. The lodge turned out to be a less expensive way of maintaining patients in the community. Sanders concluded that

several principles were involved in this method. First, participants must have a stake in maintaining the community lodge. Next, members must have as much autonomy as possible and the lodge should have a vertical organization. Finally, although the lodge must be compatible with its environment, internal norms, tolerant of deviant behavior, must be established. Also, members should have unrestricted entry and exit from the lodge and should perform in groups whenever possible. The above suggests that often the needs of the chronic schizophrenic could be met by continued group experiences in the community.

The New Jersey Rehabilitation Commission (1974) reported a project demonstrating the effectiveness of a rehabilitation house combined with a day care center program, a continuum of services combining a halfway house with a home-like atmosphere, staff teamwork and community involvement in an average six-month stay. Supportive and intensive counseling, prevocational evaluation, vocational training and re-socialization were given to 300 institutionalized patients over three years. Twenty-six percent were not rehabilitated and 23 percent were still in process. A day center was considered an important support to the residential program and responsible for the successes the project noted. The project could, of course, not indicate the aspects of long-term adjustment of the 51 percent rehabilitated. It noted, however, that the halfway house would have been insufficient compared to a combination of halfway house and day care center.

Lamb and Goertzel (1971) observed the effects of a high expectation and low expectation environment on long term mental patients randomly assigned to one of two community settings. High expectation settings, a halfway house, a day care center and a rehabilitation workshop were found to increase the patient's level of vocational and social functioning. The high expectation group was less likely to be labelled deviate, less stigmatized and less segregated. In a second study, the authors found that while a high expectation setting results in enriching patient lives, state hospitals or institutions may continue to meet the needs of a particular group of long-term patients. This study both indicates the need for coordinated programs, but also proposes a differentiation between those patients who may continue to function under "low expectations."

Richmond (1970) pointed out a need for post halfway house accommodations for patients who require more than a transitional living experience. The satellite housing program of San Mateo County, California, provides long-term psychological, social and physical support for the patient unable to live fully independently in the community. This is an alternative to re-hospitalization. Under this program, selected halfway house residents, often in groups of two, three or four, are discharged to live in community apartments, duplexes, or houses procured by the halfway house staff. A contract between occupants and agency, which clearly specifies their expectations and responsibilities, is made. Follow-up services for the occupants include continuing outpatient treatment and group counseling.

Fischer, Nachman and Ayas (1973) describe a program offering aftercare services through a family service agency. The family agency, because of its non-medical nature, was considered to effectively supply aftercare services

where volunteers could be utilized. The project served a total of 113 clients and their families over three years of demonstration. The most frequent diagnosis was schizophrenia. Early contact with the client and his family was discovered to be most important. Stages for the discharged client were described and included initiation, vocational planning, consolidation and graduation. The aftercare worker in the project assumed a role of client advocate in gaining community acceptance, housing and recreation. Follow-up data indicated that of clients served, 27 percent who received these services needed re-hospitalization and more than half were employed. The authors propose that a model of public and voluntary agencies working together would prove more successful than either working alone.

In an earlier study, Loeb and Scholes (1966) reported an effort by Horizon House in Philadelphia to return program dropouts to active status. Home visits and telephone calls were used to discover factors which might differentiate dropouts from a control group of active clients. Findings indicated that almost 40 percent of the clients contacted resumed an active status in the agency. There was no significant difference between the two approaches. Results indicated that dropouts did not differ from clients who remained active. Likewise, clients who became reactivated did not differ from those who did not respond further. This study seems to indicate that sometimes massive efforts are not required, but minimal contact and the arrangement of minimal contact, perhaps through volunteers, is useful.

The variety of transitional strategies described above were selected to illustrate several aspects of transitional programs. First, most models have accepted the fact that rehabilitation for the chronically mentally ill is open-ended. The above programs describe such linkages as residential programs followed by aftercare, long-term placement in private homes, the need for continued group experience as with the lodge program described by Sanders, and follow-up of program dropouts. Second, approaches have ranged from partial and minimal contact, such as brief interviews and telephone calls, to intensive contact. Third, the use of families, advocates and landlords point to a growing trust in the use of non-professionals in long-term community and vocational support. Fourth, social, interpersonal and community goals were accepted as parallel with, and sometimes more important than, vocational adjustment alone. The comprehensive rehabilitation center has emerged as an answer to the above conclusions. A brief mention of an illustrative program is appropriate.

Fountain House (1975) has developed a "pre-vocational day program" for its predominantly chronic and schizophrenic former hospitalized patient group. All members are unemployed when arriving at Fountain House and are dependent upon some form of financial aid. The pre-vocational day program involves a clubhouse in which all members are encouraged to participate in the day-to-day needed work. This work may involve switchboard operation, general maintenance and tour guides. This allows the client to develop work skills, or at least pre-vocational skills. Also, the Fountain House has the "transitional employment program." When members of Fountain House (former patients) feel they are ready, they are placed in work situations within one of a number of New York City business firms. The placement does not include a reference to past history, employment references or applications. A member of Fountain

House staff goes with the patients and performs the job first and is thus able to teach the job to the client. The staff member remains at the placement site with the client until the client feels comfortable - this has been found to be anywhere between a few hours to one or two days. This may be combined with a program in which members of Fountain House are placed at a job site as a group. It is understood that most members go through two to four placements before they find their own job. This placement program, the author described, not only gives the client confidence in his/her ability to work, but also supplies him/her with references of employment when looking for employment. The primary advantage of this approach is that the work environment is not simulated - instead there is real pay and responsibility.

The Fountain House experience points to the importance of psychosocial adjustment, combined with attention to "phasing" the work experience of the long-term mentally ill. Other models for work adjustment and job placement should be mentioned. This is preceded by a brief mention of employer attitudes.

An example of a study of employer attitudes toward hiring mentally ill rehabilitants was Burden's (1971) review of employers of former patients. Each company had hired one or more mentally ill person. His findings indicated that information about the clients at the policy and employment level was most helpful. There was no preference given to either the physically or mentally rehabilitated. The pre-employment physical was given by a doctor who was aware of the exact job for which the rehabilitated person was being considered. This seemed to help to eliminate the fears of the employer regarding the applicant's suitability for the job. The immediate job supervisors were told that a mentally ill person was being considered for the job. The job supervisors were given the final decision whether to hire or reject. A few co-workers were informed, but the general work force was not. There were five unions involved with the companies and none objected to hiring the former patient.

In an earlier study, Hall, Smith and Shimkunas (1966) gave attention to factors that led to the successful employment of former chronic psychiatric patients. Data was collected from case histories for a five-year period for former patients diagnosed as schizophrenic. Factors shown to be most clearly related to continuity of post-hospital employment were the degree of residual mental illness, marital status and skill. The authors suggested that because degree of illness was a prominent factor, the necessity of continuous management was evident. Sheltered workshops should be located in close proximity to medical and professional resources provided in a comprehensive community mental health effort.

Koltuv and Neff (1968) reported a rehabilitation program related to adaptation to work as its primary focus. The 100 clients served had chronic psychiatric impairment that included unstable or minimal work history and residence at a mental hospital for a substantial period of time. They found that the types of clients that appeared to best profit from the services of a comprehensive rehabilitation facility were those who possessed motivation to work, have some problem or work role behavior that is clearly defined and have a minimal level of general coping behavior. The actual experience involved work evaluation and three weeks spent with the "tower" system of assessment. At the end of evaluation, a vocational recommendation was made from one of several place-

ment alternatives. The author proposed the use of graded transitional steps, provision of a comprehensive network of rehabilitation services and the desirability of basing vocational assessments upon direct observation in work related settings.

In a different approach to job placement, Newman (1970) suggested that traditional methods of restoring socio-vocational functioning are inappropriate. He proposed a new program involving first immediate job placement at the start of rehabilitation, and second, after the client was employed, vocational behavior and shaping of appropriate work habits and interpersonal skills would be attempted. Non-professional leaders and activity groups would be used. He proposed that the traditional training approach does not meet the patient's immediate financial needs and may increase the anxiety of formed patients who have met failure with similar situations. The school or training site may actually provide a "shelter" to avoid confronting reality. The success of his program relied upon contracting with industry that a position will remain filled and if the client misses work, his duties will be temporarily taken over by a non-professional.

From the above, it can be seen from the past ten years of placement experience that the traditional method of job placement, with brief follow-up, is not always appropriate for the long-term mentally ill. In addition to work adjustment, the process itself may involve many placements and attempts by the client. Long-term follow-up and repeated hospitalizations may remain an important or continuing feature of the chronically mentally ill. Schaefer and Bartholow (1973) followed 73 clients from the rehabilitation program of the Nebraska Psychiatric Institute. Their results indicated that 73 percent of the sample had at least one interruption - an acute break in their employment, work adjustment or training. Only 19 of the 73 clients were able to complete the two-year project without interruption. This is confirmed by an early study of Deane and Brooks (1973). They followed 263 chronic hospitalized patients who were in the Vermont State Hospital over a five-year period. They found that two-thirds of their group of former patients could be maintained at effective levels of employment and functioning if sufficient transitional facilities and adequate aftercare treatment are supplied. Further, continual return to the hospital and re-release patterns are common with this group. Elements of a coordinated service model for the range from hospitalization to a period long after discharge. The best arrangement may be referral to rehabilitation programs well before discharge from the institution. With the loss of natural support systems early efforts are needed to find alternatives before the client is discharged. Discharge should be planned with consideration that severity of the diagnosis and attitudes of all agency practitioners will effect initial adjustment to the community. Halfway houses and other transitional settings are now well established means of transition to the community. Comprehensive rehabilitation centers are effective, but there is no indication that it is useful to locate and conduct treatment in the same setting. Landlord supervised transitional settings and other uses of volunteers should be increased in the 1980s. It was noted by several observers that rehabilitation can only be planned and carried out with the expectation of giving long-term support to the chronic client. Preparation for work should be graded and job placement should be made with the expectation of interruptions and "breaks" in employment. Finally, overly vigorous rehabilitation efforts can have negative results with clients who may need "low expectation" settings.

The preceding survey of agency experiences and research leads to a number of observations and conclusions:

1. Effective programs for the long-term adjustment of the chronically mentally ill result when multiple resources are used.

2. The use of paraprofessionals in job support, follow-up, crisis intervention or for other services, has not been fully explored.

3. Problems of job placement and community adjustment remain at about the same level as they did ten years ago for the chronically mentally ill.

4. Service linkages have occurred at the agency level rather that at the geographical, community or inter-agency level.

5. Success with the chronically mentally ill client may vary in terms of the intensity of post-hospital or post-placement contact, but some type of continuing contact is always needed.

6. Community and vocational adjustment are linked and should be considered an open-ended process.

7. The community as such is not intrinsically curative or rehabilitative.

8. Rehabilitation planning should go on with the expectation of interruptions, re-hospitalization, or occasional exacerbation of symptoms.

9. Community and employer attitudes toward the chronically mentally ill have not appreciably changed or kept pace with changes in general attitudes about mental illness.

10. Low expectation and terminal settings for the chronically ill have not been explored.

The following recommendations are made for coordination of rehabilitation services during the 1980s:

1. Client advocates and follow-along personnel should be assigned during or at the time of the client's hospitalization and remain with the client throughout long term adjustment. The 1970s are replete with cooperative agreements and schemes for interagency coordination. This proposal suggests that coordination of services at the agency level may be less feasible than coordination at the client level. Individual public and private agencies will always be limited by internal policy and by funding. Further, the literature has shown that many chronic clients break off contact. The advocate with the continued responsibility for being in touch with the client would be a solution to this problem. The task of coordinating agencies and services would be shifted to the advocate's

task of assuring that the client is in contact with all services. At one level, everyone in rehabilitation considers himself an advocate of the client. However, few advocates have responsibility for total contact. What is proposed here is that a specific group or consortium of agencies develop and implement a position of a mental health advocate who has contact and referral skills.

2. Planning for services should be individually tailored, with few provisions for time limited contact.

3. Overlapping programs should involve the local - citywide or countywide - consortia of agencies that could be directed by a joint team with central administrative responsibilities. This would include the total health care of the chronically mentally ill client.

4. The work of volunteers and paraprofessionals in all stages of the client's experience from transitional facilities, job placement and follow-along with families or within the community should be further explored.

5. The outlook of competitive employment may be only one of several alternatives for the chronically mentally ill client. Large scale residential and terminal workshops, where the individual client may live as well as work for contracted employment, should be considered. Services such as medical support, counseling, recreational and independent living could be given within this semi-protected setting.

6. Assignment of volunteers to former patients' families and other support groups should be a direction in the next decade. Natural support systems should be explored - family, friends, self-help groups, advocacy groups and others should be explored in the coming decade.

7. The organization of whole systems of comprehensive care may not be possible in all areas. The supplement for this type of organization could be the individual advocate for the client who assures that he/she remains in contact with all community resources.

8. Industry has not been consistently involved for competitive job placement. A national level consortium of industries should be planned for the chornically mentally ill.

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EXCERPTS OF REVIEWS AND COMMENTS

The following are excerpts of reviews, comments and questions raised by the Switzer Fellows. These are presented to further stimulate thinking as well as action as it relates to the content of the paper by Dr. Schumacher.

"Dr. Schumacher, in his paper, "Strategies for Coordinating Services in the Rehabilitation of the Mentally Ill," has done all of us a considerable service by reviewing the literature of the past 15 years and summarizing what we know that works and how we came to know it. He makes clear that the period has been a search for appropriate models and that no consensus has emerged. He does, however, note the consistency with which good community support systems appear to be related to lowered rates of rehospitalization. Although he does not go the next step - to look at how good community support systems might be related to lowered rates of initial hospitalization - this does seem to be an appropriate next step in the research agenda.

Some of the work of the Industrial Social Welfare Center at the Columbia University School of Social Work has shown that early case finding by easily accessible, unstigmatized services located at the work place, can often intervene in the deterioration process and achieve job maintenance of the person potentially disabled by a mental illness. The model of the alcoholism program(s)/counselor(s) is relevant and might be tested further. (The experience of several European countries in community support programs and preventive rehabilitation for those with a history of mental illness might well be reviewed for important lessons).

In matters of re-employment, Schumacher points out that the literature is once again nondefinitive but it appears that a prior work history is instrumental to successful vocational rehabilitation for most emotionally disabled persons. Although he discusses the Fountain House model, which attempts to develop a work history for its members by placing them on transitional part-time jobs, in serial order, he does not deal with the role of sheltered workshops. It seems to me that such workshops could have programs of graduated assignments which would take the "almost rehabilitated" client into employment in an enclave setting at the site of the contractor rather than at the workshop performing the contracted work in a sheltered setting. There is a need, in suggesting strategies for the '80's both to take the lessons of the past - as Schumacher does so well - and to deduce and test the next step in the vocational rehabilitation process.

The author also reminds us of an important point - that rehabilitation of the chronically mentally ill is "open ended." The need in relation to an individual client never stops. Policy makers must recognize this commitment and the long-term cost it represents. The quest in the care of those with emotional illness cannot be to save money - as the recent deinstitutionalization movement has attempted - but rather to spend money more effectively and more humanely."

-- Shiela H. Akabas, Ph.D.

"Research is needed which attempts to match client needs with program elements in a more scientific way. Clear objectives are also important. It is not evident that employment contributes to satisfactory adjustment. We should look at whether or not the goal of employment may not place too many pressures on the client and exacerbate the rehabilitation process.

The problems of readmission and follow-up services for the mentally ill are especially significant to persons who yield from lower class backgrounds. More discussion of the impact of class on the rehabilitation of the mentally ill would be helpful. Of particular concern is the coordination issue in impoverished areas.

Rehabilitation personnel need specific training in linkages and liaison work. Currently there are few opportunities to learn how to assess an agency's potential, diagnose client needs and affect a good marriage between the two.

The RSA-NIMH agreement is a step in the right direction at the Federal level. Unfortunately the real level of intervention is at the local level where little seems to be accomplished. Legislation in the future should pay more attention to achieving program integration at the local level in addition to the Federal initiative.

The specific strategies and directions of rehabilitation (policy) need to be reviewed in light of the coordination issues raised by this author. Highlighted by this review is the fact that coordination remains a problem for field."

-- Robert J. Grantham, Ph.D.

"There is some question about the attitudes of professionals toward the mentally ill according to Wycus and Carluccio. Evidentially attitudes of professionals, employers, and the community are not favorable toward the 'chronic mentally ill'. Perhaps one way to alter attitudes would be for former patients to demonstrate their abilities to function in an average way in the community. There are former patients who can and will speak out, but there needs to be some organized effort nationally that will allow us to be seen and heard in places where it counts! We must speak for ourselves! Patients respond to a peer who says 'I understand what you are saying', 'I know how you feel'. If enough exposure is made of former patients who are functioning in an average manner perhaps the professionals, employers, etc. will take a more favorable attitude.

I see the importance of coordinating a core of volunteers from the community, para-professionals, former patients, and others into advocates for the patients. This would help the family members to relate and take some interest in the progress of the patients, and the patient would have one person who would know their strengths/weaknesses, i.e. someone who may be more approachable than the traditional professional. The patient needs 'peer' support. I caution that the advocacy role may foster dependency after a while - work on short range goals encouraging the patient/member to help plan, decide, and act with the advocates support. What do the patients want? They need to develop a way of leadership for themselves."

-- Nancy Downes

"While Dr. Schumacher arrives at a number of excellent conclusions, I question whether service linkages have occurred at the agency level. There seems to be more a game of 'you pay for it'. The decision to cooperate and to provide matching funding needs to be very strongly expressed at a federal level and also strongly expressed at a state level. This commitment is absolutely essential.

The conclusion that services need to be open ended is also crucial since too many funding sources place time limits on programming.

The concept of an advocate or case manager following the client into the community and linking up with various agencies and services is very important and is currently being done by my agency successfully.

Dr. Schumacher as well as the other individual's papers have not addressed a critical issue, a continuum of services. While there is discussion of the dire need for working with the mentally ill as individuals, most of the programs look to deal with the whole population. Within that population of individuals are many levels of functioning. These levels must be carefully reviewed and plans made accordingly."

-- Steven M. Fishbein, M.A., CRC

"If community adjustment and vocational adjustment are linked, then the goal of more independent living must be perceived as a relevant vocational rehabilitation goal for the psychiatrically disabled. It is also recognized that the rehabilitation process (for the mentally disabled) is usually long-term, not time-limited, with interruptions, losses, etc. These factors have serious implications in the system of accountability of State DVR Agencies."

-- William A. Anthony, Ph.D.

SUMMARY OF RECOMMENDATIONS

The following is the summary of recommendations and implications for action as developed by the Switzer Fellows for the topic of the third paper (The Recorder was John R. Pelletier):

POLICY AND PROGRAM DEVELOPMENT

There appears to be a lack of awareness among both rehabilitation and mental health professionals regarding the conceptualization of new program models such as the Community Support Program (CSP) approach. While RSA and NIMH have forged agreements at the federal level, understanding of federal objectives has not been effectively communicated to the field. Accordingly, there needs to be increased federal and state leadership in support of greater coordination and integration of services at all levels of service delivery, including emphasis on the CSP approach.

Overlapping programs should involve the local-urban and rural consortia of agencies which could be coordinated by an area-based interagency team with centralized management responsibilities. This would facilitate the total rehabilitative care of the mentally ill. The CSP model is one example of this approach.

Industry has not been consistently involved in competitive job placement. A national level consortium of industries should be planned with an emphasis on employment of persons who had emotional difficulties.

There needs to be increased citizen and consumer participation in the planning, as well as delivery, of rehabilitation services.

There needs to be greater involvement by rehabilitation and mental health professionals with the total community, including the political system, in the planning and delivery of rehabilitation services. This includes realistic assessment of a community's capacity to provide basic support to the mentally disabled individual. It is important to recognize that a community may not be ready to provide a supportive environment in which rehabilitation may be facilitated.

There needs to be more careful attention to ethnic and cultural needs in the planning and implementation of rehabilitation programs. This is particularly important in delivery of services within impoverished and/or underserved areas.

RESEARCH

There needs to be a strong emphasis on incorporating program evaluation and research strategies into area-based programs, including the evaluation of programs in general, as well as of specific treatment modalities. Attention should be paid to process as well as outcome. This is especially important in evaluating the effectiveness of CSP models which are a new development in the delivery of rehabilitation services.

Research is needed which attempts to match client needs with program elements in a more scientific way. This includes attention to ethnic and cultural factors in service delivery.

There needs to be research regarding the process of case-management as an ongoing function in service delivery, including its impact on client adjustment in the community.

There needs to be research related to the role and effectiveness of varied self-help approaches in the rehabilitation process.

Research is needed regarding community variables which support or impede the rehabilitation of the mentally ill.

SERVICE DELIVERY

There needs to be greater emphasis on the role of case-management, including advocacy, to facilitate client access to services. This should begin during or at the time of a client's hospitalization or entry into the system, and remain with the client throughout an essentially open-ended rehabilitation process. Case-management is viewed here as an important and necessary function which can be performed by professionals of varying disciplines. It may best be provided by the individual with the strongest relationship with the client. Case-management is a process of 'tracking people' and not paper!

Planning for services should be individually tailored with recognition of the need for a process which is open-ended rather than time limited in scope.

Case load sizes are much too large in many state vocational rehabilitation agencies which frequently impedes rehabilitation counselors in these agencies from providing more effective and timely client services. This includes participation in an inter-agency rehabilitation team. Too much has been expected of the Federal-State program with usually too little financial support.

The utilization of both volunteer and paraprofessional personnel needs to be explored. It appears necessary that assessment of the Rehabilitation Act be made regarding both types of personnel, and should such personnel be utilized, attention needs to be paid to functions and responsibilities, qualifications, training, and supervisory needs.

Within the service delivery component there needs to be identification and maximization of natural support systems, including family, friends, self-help organizations, religious and other community organizations and resources.

Competitive employment may be only one of several vocational alternatives for the chronically mentally ill client. For many individuals, long-term sheltered employment opportunities are needed. Such programs should have the necessary financial support, and be well integrated into the larger support system, including residential support.

Within sheltered rehabilitation programs, normalization should be emphasized, including development of programs to facilitate transition to more competitive and normalized settings. Projects with industry, and varied transitional employment programs are examples of this effort.

The organization of whole systems of comprehensive care may not be possible in all areas (e.g. rural). Where gaps in systems occur, however, the case-management role is especially important to assist clients in gaining full access to existing services.

TRAINING OF PERSONNEL

In light of apparent lack of understanding and skill among many rehabilitation and mental health administrators, there is need for training directed at changes in attitude and approach to the delivery of services. One approach should be to expose personnel to already existing models of effective service delivery.

Rehabilitation personnel need specific training in linkages and liaison work with other community and mental health service agencies.

Greater emphasis should be placed on training with all levels of mental health professionals in assisting clients to develop necessary competency based skills to succeed in community living.

In using volunteer and paraprofessional personnel, there needs to be attention to their training and supervisory needs.

There needs to be specific training in the role, utilization, and development of self-help modalities in serving the psychiatrically handicapped. Our goal should be to create more "helpers" rather than relying too heavily on professional personnel.

There needs to be greater emphasis on training rehabilitation and mental health personnel in a systems approach to client intervention, that is, the attention to the role of significant others in both family and community.

LEGISLATION

The Rehabilitation Services Administration - National Institute of Mental Health (RSA - NIMH) agreement is a step in the right direction at the federal level. Yet, the real level of intervention must be at the local level. Future legislation should pay more attention to achieving program integration at the local level in addition to the federal initiative. Legislative priorities should be set within a framework of more effective and pragmatic collaboration between local, state and federal government.

There needs to be increased medical insurance coverage to support longer periods of inpatient and outpatient rehabilitation services which are often needed with some psychiatric involvements.

CHAPTER FOUR

PRETENSIONS AND REALITIES OF REHABILITATING THE MENTALLY ILL

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SUMMARY OF PAPER

This paper focuses on the treatment philosophy and program elements of the Harlem Interfaith Counseling Service, Inc. which serves mainly minority clients in an urban area in New York City. The agency is a voluntary, outpatient mental health clinic established in 1966. The clinic specializes in services to adults and adolescents. This paper discusses the issues of functional versus dysfunctional clients, a description of a treatment/rehabilitation program operating in Harlem, including intake procedures, goal-setting, initial interventions and special concerns of adolescents. There is also an emphasis on sensitivity to cultural and ethnic factors in service delivery. McKinney and Dennard raise some thought-provoking concerns about the treatment of chronically dysfunctional patients in the Harlem Community, but stress a number of positive approaches in working with the functionally mentally ill.

INTRODUCTION

Rehabilitation of the mentally ill is possible. True or false? The question cannot be answered that simply. Who are the mentally ill we are rehabilitating? The mentally ill are not all the same and must be categorized in order to know who we are actually dealing with and what their needs happen to be.

We would subdivide the mentally ill into two major categories, the functional and the dysfunctional. Those in the functional category, though handicapped in their functioning by their mental illness, undertake responsibility for themselves and their families. They work, either at outside employment or as homemakers. They are taxpayers, generally. Those in the dysfunctional category do not undertake responsibility for themselves or families. They do not work and they do not perform as homemakers. They are tax consumers.

It is our impression that a significant number of the most influential policymakers and theorists in the mental health field believe that the dysfunctional mentally ill category can be rehabilitated and, therefore, the largest portion of mental health rehabilitation money is directed at this dysfunctional group. Is this an economical expenditure of rehabilitation money? What is rehabilitation supposed to mean anyway?

The dictionary definition of rehabilitation is: "the action or process of restoring to a former capacity or state (as of efficiency, good management or solvency)." In the case of the mentally ill, the total and comprehensive treatment process can be referred to as rehabilitation. In mental health rehabilitation, therefore, a person is to be returned to a former functional state. It is not likely that a functional state can be developed in a person unless it has been present previously. That is the rub in the planning and expenditure of mental health funds throughout much of the United States. Rehabilitation/treatment money is used largely for persons who have not functioned in the past. If they did function at all in the past, it was for brief periods only and then probably only in childhood and adolescence when they were being supported by parents and did not have essential responsibility for self.

To what functions are the chronically dysfunctional mentally ill to be restored? Can they be restored to being self-supporting or to supporting a family or even to properly taking care of the premises in which they live? We haven't seen evidence to support the notion that the chronically dysfunctional can be rehabilitated into a functional state.

ATTITUDES ABOUT TREATMENT OF THE FUNCTIONAL VS. THE DYSFUNCTIONAL

Rehabilitation/Comprehensive Treatment does not take place in a one or two dimensional arena. It takes place in a multi-dimensional sphere. The participants include the client, the family of the client, the community of the client and the mental health professionals treating the client's disability. Without the involvement of all of these participants, little or nothing can happen. Now, how do we get them involved in the Rehabilitation/Treatment process? Few, if any, are going to become involved in "restoring" a person to functioning who has never functioned before. No one will put effort into a hopeless situation. Past ability to function provides that absolutely essential ingredient of Hope to those who must become participants in the rehabilitation process.

What are the client's rights in rehabilitation/treatment?
What are the family's rights in rehabilitation/treatment?
What are the community's rights in rehabilitation/treatment?
What are the mental health professional's rights in rehabilitation/treatment?

First, the client: The client has a right to choose rehabilitation/treatment or to reject it. His behavior gives his answer. Generally those who have functioned in the past choose to be treated, to be restored to functioning. Just as generally, those who have been chronically dysfunctional, reject treatment. The latter do indicate they want something, namely to be taken care of.

Next the family: The client's family has a right to choose to participate in the rehabilitation/treatment process or to reject such participation. The family's behavior gives its answer. Where the client has functioned in the past, his family is motivated to help him in the process of restoring his functioning capacity. Where the client has been chronically dysfunctional, the family cannot be motivated to expend energy fruitlessly trying to turn its

contentedly dysfunctional kinsperson into a functioning citizen. Some families, with enough living space and affluence, will, out of familial love and duty, provide for this relative, but as if he were a small child. Most families, having little living space and no affluence, protect themselves from the client's irritating and often offensive behavior by ejecting them from the family.

Next, the community's rights: The community has the right to choose or reject participation in the rehabilitation/treatment process. The community generally chooses to participate in restoring the formerly functional client to a functional state. The community insists on the removal of the chronically dysfunctional from the community, but is frustrated nowadays by new legislation that mandates returning the chronically dysfunctional to the community. The community tries to ignore them, putting them into the "new institutions" -- the SRO's -- and gradually removing the SRO's from the better politically organized parts of town to the least politically organized parts of town.

Lastly, the rights of the mental health professionals: Mental health professionals also have a right to choose or reject participation in the rehabilitation/treatment process. They generally choose to participate when the client's history indicates a formerly reasonable functioning level and current examination procedures indicate current motivation and readiness on the part of the client to become functional again. In the absence of such a history, or to put it another way, in the presence of a history of chronic dysfunctional behavior, the mental health professional most often rejects participation in any attempt at rehabilitation/treatment. This is clearly evidenced by the behavior of these professionals. They generally do not accept chronically dysfunctional clients in their private practices and they generally won't go to work at institutions (hospitals, clinics, etc.) that service the chronically dysfunctional client, except out of economic necessity. When they have secured other means of support, they withdraw from work in these institutions. These institutions are, therefore, chronically understaffed by professionals.

Does the foregoing indicate that the chronically dysfunctional person should be abandoned by the community? Not at all! It does mean that such a person is not a client. A client is someone who avails himself of treatment. These people do not avail themselves of treatment. They do avail themselves of receiving custodial care, but that may be all. We should provide custodial care and in the least restrictive manner, possibly in semi-open, mini-institutions. How custodial care is provided is important, but not germane to rehabilitation/treatment of the mentally ill. What we have been driving towards is that mental health money (i.e., treatment money) can be rationally employed only in the treatment of those mentally ill persons who are functional now in spite of disability or those who have been functional until recently and have a state to which to be restored.

These latter two subcategories of the functionally mentally ill are legion, much more numerous than the chronically dysfunctional persons. But most often, the extent of their disability is minimized, even by mental health professionals. Others don't see their need. Additionally, most often they are ashamed to make their need for rehabilitation/treatment known. Some don't even recognize that their disability is correctable.

DESCRIPTION OF A TREATMENT/REHABILITATION PROGRAM IN OPERATION IN HARLEM, NEW YORK CITY

At Harlem Interfaith Counseling Service (hereafter to be referred to by the acronym HICS), we are in the profession of treating/rehabilitating the mentally ill. The foregoing material has provided our conceptual framework about who can utilize treatment meaningfully. Now we will describe the HICS' programs, as we have designed them, to treat those, whom we have learned from long years of experience, will benefit from treatment.

At HICS, we treat/rehabilitate two subcategories of the mentally ill:

1. those who are functioning in the community in spite of mental disability;

2. those who have functioned until recently (up to one - two years) and, therefore, present a history of having functioned in the community (at age and developmentally appropriate tasks).

Harlem Interfaith Counseling Service, a licensed mental health clinic has been established to provide high quality, outpatient mental health treatment services to those individuals of the Harlem community in need of and able to use treatment for mental disabilities. The services are delivered in a comprehensive and culturally compatible manner.

Harlem is an area where the mental health of its population is at high risk because of extremely inadequate education, a higher unemployment rate than elsewhere in the city, a higher crime rate than most parts of the city and extremely poor and dangerous housing conditions. Persons living under these kind of environmental stresses are highly susceptible to developing disorders of behavior, feeling, thinking and judgment. There is a decline in the effectiveness of the extended family and a marked deficiency of supportive social services which act or function to prevent mental breakdown and which enable persons to cope better with mental disabilities.

HICS is continually seeking to develop treatment approaches which will convey to Harlem residents that the essence of treatment/rehabilitation is to enable them to better utilize their strengths in overcoming whatever disabilities may be hampering them. We want to develop treatment approaches that engage people because they promote good expectations from them.

I. ADULT TREATMENT UNIT

The following program elements approach the mental health service needs of families experiencing mental disabilities from the point of view of the adult members of the family unit. These program elements include:

1. Therapeutic Intake Process (Evaluation and Diagnosis)
2. Individual Psychotherapy
3. Group Psychotherapy
4. Family-Oriented Psychotherapy
5. Chemotherapy

The goal of all services is to increase the capacity of adults to function effectively in the home and community, despite mental disabilities.

II. ADOLESCENT TREATMENT UNIT (a/k/a The Mustard Seed Learning Center)

The following program elements approach families needing mental health services from the point of view of adolescent family members. The service elements include:

1. Evaluation and Diagnosis with the following special characteristics for this client population:
   a. Rapid-Comprehensive Intake Process - this element is designed to ensure that no adolescent with a mental disability needs to wait longer than one week to be seen.
   b. Initial Intervention Process - designed to educate and to motivate adolscents and parents. This population needs to be taught:
      1. what mental health services delivery is;
      2. how to effectively participate in a structured program of change;
      3. how to actively follow through on decisions for change.

2. Individual Psychotherapy for Adolescents and Adults - as they acquire the capacity to participate meaningfully in this program element.

3. Group Process Treatment for Truants with Emotional Disorders - combines behavioral therapy, group psychotherapy (stressing motivational techniques) and specific teaching of skills necessary to achieve learning success.

4. Psychological Testing for Adolescents (to clarify both personality dynamics and achievement potential).

5. Chemotherapy

The Adult Treatment Unit and the Adolescent Treatment Unit interact through:

   a. clear referral processes;
   b. appropriate conference structures;
   c. specific psychiatric supervision.

GOALS:

On our part, there is and must continue to be a continuous effort to develop and integrate a variety of treatment modalities geared toward enabling the functionally disabled to cope more effectively with the high risk factors in their community through:

1. the reduction in disorders of thinking;
2. the reduction in disorders of feeling;
3. the reduction in disorders of behavior;
4. the reduction in disorders of judgment.

The reduction of these disorders, which impair the use of functional coping mechanisms, leads to:

a. the reduction of intrapsychic conflict;
b. the reduction of interpersonal conflict;
c. the reduction of marital conflict;
d. the reduction of parent-child conflict;
e. the reduction of job conflict.

It is our premise that most mentally disabled persons in this community, who are not chronically dysfunctional, will accept mental health services and can be helped to function effectively if mental health treatment services are provided which adequately respect their inherent dignity and which respect their cultural background.

OBJECTIVES:

As has been described, Harlem Interfaith Counseling Service has two treatment programs. We will now describe the treatment objectives for clients in each program.

I. ADULT TREATMENT UNIT

1. Restore or rehabilitate the ability to perform household responsibilities such as:

   a. paying bills on time;
   b. cooking and cleaning;
   c. shopping for needed supplies.

2. Restore or rehabilitate the ability to perform parental responsibilities such as:

   a. giving wise guidance, independence-training and affection to children;
   b. getting children up, dressed properly, fed and taken to school or sent off to school on time;
   c. providing proper structures and discipline for children;
   d. monitoring homework and intervening constructively in school behavior that has become dysfunctional behaviorally or academically.

3. Restore or rehabilitate the ability to perform work responsibilities such as:

   a. going to work daily and on time;
   b. dressing and grooming appropriately for work;
   c. maintaining a cooperative attitude with supervisors and peers;
   d. finding areas of satisfaction on the job in order to motivate those actions that will lead to advancement;
   e. getting further education, vocational training or taking tests to promote job advancement.

4. Restore ability to combat depression, tension, worry and fearfulness through the learning of age appropriate coping mechanisms.

5. Decrease outbursts of anger and physical violence through the teaching of more effective communication skills.

6. Channel withdrawal and isolation into discovery of interests appropriate to age and opportunity.

7. Decrease conflicts with family members and neighbors by encouraging discovery and development of personal influence skills.

8. Decrease confused feelings or forgetfulness by teaching problem-solving and decision-making skills.

9. Restore capacity to think logically and realistically by remission of distortions in thinking.

10. Channel dysfunctional passivity into increased self-confidence.

11. Decrease abuse of alcohol and other abusive substances by encouraging increased use of mental and spiritual capacities.

II. ADOLESCENT TREATMENT UNIT

The following are addressed to the adolescent patient himself. In the case of the involved parents, the objectives are the same as those listed for the Adult Treatment Unit above.

1. Restore or habilitate the ability to perform school related responsibilities such as:

   a. going to school daily and on time;
   b. doing homework conscientiously;
   c. cooperating with teachers and peers;
   d. going to school sober and remaining sober while carrying out school responsibilities.

2. Restore or habilitate the ability to relate reasonably in the child-parent relationship such as:

   a. keeping reasonable hours;
   b. performing reasonable household chores;
   c. adhering to reasonable parental rules.

3. Restore or habilitate the ability to relate reasonably to authorities outside the home.

4. Restore or habilitate the ability to adhere to community rules and laws established to protect others such as:

a. not stealing from persons or places;
b. not being assaultive or threatening;
c. not getting into fights;
d. not becoming violent.

5. Habilitate the ability to perform work related responsibilities (for adolescents in and out of school) such as:

   a. going to work daily and on time;
   b. dressing and grooming appropriately for job interviews and for work thereafter;
   c. maintaining a cooperative attitude with supervisors and peers;
   d. finding areas of satisfaction on the job in order to motivate those actions which will lead to advancement;
   e. getting further education, vocational training or taking tests to promote job advancements.

6. Restore ability to combat depression, tension, worry and fearfulness through the learning of age appropriate coping mechanisms.

7. Decrease outbursts of anger and physical violence through the teaching of more effective communication skills.

8. Channel withdrawal and isolation into discovery of interests appropriate to age and opportunity.

9. Decrease conflicts with family members and neighbors by encouraging discovery and development of personal influence skills.

10. Decrease confused feelings or forgetfulness by teaching problem-solving and decision-making skills.

11. Restore capacity to think logically and realistically by remission of distortions in thinking.

12. Channel dysfunctional passivity into increased self-confidence.

13. Decrease abuse of alcohol and other abusive substances by encouraging increased use of mental and spiritual capacities.

CRITERIA FOR SELECTION OF THERAPISTS AND ADJUNCTIVE SPECIALISTS FOR THE REHABILITATION PROCESS:

THERAPISTS

We look for therapists with (a) a good capacity for empathy with others; (b) a fair degree of maturity in outlook about life in general; (c) experience with growing up or living in the Black urban community.

These qualities make for a therapist who understands the culture of our clients because of his/her own personal experiences of living in it, who will focus more on strengthening the client's assets and coping mechanisms for

dealing with his disabilities. This type of therapist shoud not feel sorry for the client, but should teach the client patience with himself by placing his behavior into the context of universal behavior.

ADJUNCTIVE SPECIALISTS (Sources to which the client is referred for rehabilitative services we do not provide)

We look for the adjunctive services to be provided by persons:

a. who have shown a strong interest in persons as human beings in contrast to an interest in them primarily as objects for research or teaching others;

b. who have demonstrated an ability to communicate clearly to and to respect the dignity of the client;

c. who, as often as possible, come from a culturally compatible source and may be less likely to underestimate the client's intelligence and capacity to cope (i.e., who will, therefore, minister primarily to his strengths rather than primarily to his disabilities).

THE REHABILITATION PROCESS ITSELF

A comprehensive longitudinal psychosocial history is the chief evaluative instrument used to identify the nature and chronicity of the person's disability or disabilities. This history is carefully reviewed by the intake evaluation conference, which is chaired by the psychiatrist. In the case of adults, whenever the emerging history suggests complex pathology causing the disability, the psychiatrist and often the psychologist evaluate the clients in direct examinations. In the case of adolescents, the psychiatric and psychological exams are routine for all the clients because adolescents are less able to articulate their areas of disability.

These evaluations, especially the longitudinal history, indicate the strengths and coping capacities of the client, invaluable information for formulating short and long term treatment goals and for aiding in determining the focus of the psychotherapeutic input.

Obtaining a reliable longitudinal history is often very difficult, especially with those adolescents whose family and community lifestyles predispose them to express mental disabilities in anit-social acting out behaviors. Their families are often referred to as multi-problem families. Their lifestyles are characterized by behaviors initiated primarily by the emotions, with little or no input from the intellect. Another way of describing this phenomenon is that the behavioral output is primarily reflexive rather than reflective. The result is that such adolescents and their families, not being in the habit of thinking reflectively, have a more difficult time presenting a history of their behaviors in a coherent sequential form. Behavioral output, based on purely emotional reactions, is related to primary process thinking. In primary process thinking, time is inexact and mostly irrelevant. Cause and effect relationships become so confused that they become irrelevant too.

We found that with this population of our clients, there was a need to develop special approaches, first of all, to engage them, to motivate them into a realization that they need help and then, secondly, to obtain the essential historical information which will delineate the person's disabilities.

Mrs. Doris Dennard, the Assistant to the Clinical Director and the supervisor and administrator of Harlem Interfaith's Adolescent Treatment Unit, has described in a report the rationale for and the alterations in the traditional approaches which were necessitated by our involvement with the client population described above:

"In thinking through the question of why the needs of the adolescent are so often neglected by the mental health profession as a whole, I hypothesized the following:

A. The adolescent in Harlem is 'resistant' to treatment primarily because the adolescent seldom has the communication skills which appeal to most mental health professionals. Therefore, the adolescent expects and provokes rejection from most adults - therapists included.

B. Having experienced repeated failures, both in relatedness and in skills development, the adolescent is convinced that he is a helpless victim of an uncaring and unresponsive adult society. He develops defenses of hostility, pseudo-sophistication, denial and suppression of positive aspirations and appears not to care about what happens to him or others.

C. Chronic depression, minimal brain damage, latent psychoses often behave like truancy, delinquency, drug abuse, sexual acting out, impulsive reactions, hostility, anger and approach-avoidance. The symptoms are so overwhelming and frightening to many therapists that they often deny that they are dealing with mental illness. 'Social maladmustment' is often a denial of pathology on the part of therapists who find acting out adolescents frightening.

Because of the above, the Service Philosophy of the Adolescent Treatment Unit was designed to keep therapists mindful that the Harlem adolescent in mental health treatment is dependent on the therapist's belief in positive potential in himself and in other people. The sense of trust, as defined by Erickson, has never developed in the Harlem adolescent who needs therapy.

Adolescents in treatment with us - like all adolescents - reflect, mirror and imitate the behavior of their parents! All people learn first to view themselves as others view them. In case after case, the longitudinal history of the parent and the pathology of the adolescent are intricately entwined. Therefore, the Service Philosophy for adolescents is designed as well for the adult who is his parent or guardian.

PROGRAM ELEMENTS OF THE ADOLESCENT TREATMENT UNIT

1. Rapid Comprehensive Intake Process

The Rapid Comprehensive Intake Process was designed for three purposes:

a. In recognition of the fact that an immature, impulse-ridden population with low frustration tolerance cannot endure a long waiting period before gratification. Much opportunity to nourish defective trust and to stimulate positive motivation can be lost unless there is immediate response in the period of crisis.

b. To institute immediate decision-making process, the therapist must recognize that multiple-problem facmilies have never been taught to think with their minds. They think with their feelings and make decisions with whatever feeling is strongest at the moment. It is the therapist's task to teach the client how to reveal the presenting problem in a rational, organized fashion and help him begin to assess the cost of change.

c. To provide the opportunity for clients and therapists to decide to what extent clients are ready to invest in positive change.

In implementing the objectives of the Rapid Comprehensive Intake Process, I have noted that clients have many ways of seducing the therapist to avoid the decision-making process. Therapists are anxious for clients to make the decision to change and often have the tendency to 'put words' in the client's mouth. For this reason, I have found that cases often stay too long in the pending category because in the initial interviews, therapists are not using the techniques which enable the client to think about what investment they are ready to make to change the situation. The help of the therapist is being offered with little challenge to the client to demonstrate and clarify what the client is willing to do to help himself. A client must minimally recognize a personal choice to change his lifestyle before the client can enter meaningfully into the initial intervention process. The therapist must recognize decision-making in the rapid comprehensive intake stage of the therapeutic contact as being the principal therapeutic technique, in order to help the client consciously choose to change or not to change the symptomatic picture he is presenting.

2. The Initial Intervention Process

Because of the multiplicity of symptomatic problems that multi-problem families present, and because tracing cause and effect is so difficult for most members of disorganized family systems, we speak in the Adolescent Treatment Unit of an initial intervention process - rather than intake process. Intake process - in the traditional sense - refers to the gathering of longitudinal data sufficient for definitive diagnosis over a very brief period of time (one to three interviews). Members of disorganized family systems, such as those we have worked with in the Adolescent Treatment Unit over the past three years, have documented the initial hypothesis that deficient capacity to trust

must be taken into account in structuring therapeutic process for disorganized families. Until at least a minimal decision to do something about the chaos has been made by the client and until the client trusts - at least minimally - his own and the therapist's ability to help him - a client cannot and will not disclose longitudinal history in organized fashion. First of all, it must be recognized that because of the limited understanding of the principle of cause and effect, clients find it difficult to understand why questions that relate themselves to the past are relevant in the present. Therapists need time to educate and explain why such information is needed and how it can be significantly related to the client's present goals. What is more, it takes time for the therapist to understand the client's language and frame of reference sufficiently to give explanations in language that the client can understand! Clients often say they understand when they do not, in fact, understand. They will act out their lack of understanding by their behavior (no shows, cancellations, lateness for appointments, restlessness in the interview, avoiding eye contact with the therapist, etc.). Encouraging a client to put what he has understood of what the therapist has said in his own words can often help both to clarify and help the therapist understand more of the client's language. In short, it is important for therapists to understand and take into reasonable account the limited vocabulary skills of many adolescents and adults in disorganized families. Moreover, it is important to understand the difference between describing a client as 'not articulate' and 'clients with limited vocabulary skills.' 'Not articulate' can imply limited motivation, whereas limited vocabulary skills can connote to the therapist that the client may need and want help in putting his feelings and wishes into words that the therapist can understand. Being sensitive to this is important in the establishment of trust, mutual understanding and mutual respect in the initial intervention process.

In explaining the diagnostic process as it pertains to the involvement of other disciplines, a skilled social work clinician will recognize that lack of information, distortion and negative past experiences with professionals of all disciplines must be taken into account. For instance, social worker often means welfare investigator to clients. Clients who are or have been on welfare see a social worker as someone who pries into one's personal affairs for the purpose of proving ineligibility for help. Clients have learned over the years how to manipulate the welfare department and other human services delivery systems and they bring their survival patterns and perspectives of the social work role into the treatment relationship. The role of the psychiatrist and the psychologist is equally equated with being thought crazy. Such feelings must be surfaced so that proper information can be given to the client about the significance of the psychologist and/or psychiatrist in obtaining relief from the symptoms the client is presenting. Here again, it is important always to relate the explanation specifically to the pain, discomfort or concern that the client has articulated. General explanations will not be felt and, therefore, not understood. We must keep in mind always that we are dealing with clients who make decisions at the emotional level more often than at the intellectual level. In short, communication must be structured to communicate with the emotions as well as with the intellect. For example, an adolescent who is bored and defeated by repeated academic failure projects responsibility for his failure in learning on his teachers. He can often be helped if it is explained to him that everyone learns

differently. Empahsizing that we are interested in discovering how he learns best and discovering where his hidden talents may lie can help him to perceive with his feelings and with his intellect that a psychologist is essentially a talent hunter. This can remove the stigma and the fear of exposing his ignorance and make it possible for him to relate comfortably to the psychologist. With the parent or guardian of the adolescent, one can use and expand the above illustration by adding that a psychologist is also one who uses a variety of tests to determine what people are feeling when they can't put it into words. Adults often complain that they don't understand why their youngsters behave as they do. 'They won't talk.' Here, teaching that all people many times have feelings that they cannot put into words and about which they are not aware can be helpful. In introducing the role of the psychiatrist, the use of the word 'nerves' is a very culturally compatible term. 'Getting on my nerves' and 'getting on my last nerve' is every day language in most households. Introducing the concepts of psychiatrist as a 'nerve' doctor, rather than a doctor for crazy people is often a useful explanation.

The above is illustrative of some techniuqes that can be useful in helping a client move through the initial intervention process. The examples given imply patience, time and willingness to move at the pace of the client. We set an objective of twelve weeks for the above process and have found it to be a reasonable estimate. Some clients are able to move through the process more quickly - others take more time - others terminate before the process is complete. However, it is clear to us that the therapeutic process takes place significantly during both the Rapid Comprehensive Intake Process and the Initial Intervention Process - whether or not the client moves on to specific, more formal treatment."

The longitudinal history, the psychiatric examination and the psychological examination often point to the need for other medical studies to determine the presence or absence of other disabilities contributing to the person's inability to function in accord with his given potential. We have ready access to obtaining a comprehensive medical evaluation and, in the case of adolescents and children, a comprehensive developmental evaluation to determine the presence of and neurological basis of learning disabilities and of some behavior disorders.

Since we attempt to view each client holistically, we sort the array of evaluative material into the dimensions of personality which we see operative in all human beings: a) the physical dimension; b) the emotional dimension; c) the intellectual dimension; d) the spiritual dimension.

It is important to say something about the spiritual dimension because it is most often confused with organized forms of religion. By spiritual we refer to the fact that all people have some belief system (about themselves and their world) by which they operate. Some, nowadays, use the word "existential" instead of spiritual. By whatever name, one's belief system about himself and his world permeates and critically influences the functioning of the three other dimensions of his personality - the physical, emotional and mental. In the Intake/Initial Intervention Process, we listen with great care for evidences of the client's spiritual approach to life, i.e., whether he expects bad outcomes for himself (destructive approach) or whether he expects good outcomes for himself (constructive approach). In our clinic, we refer to this special attention to the spiritual dimension of clients as the psychospiritual approach. We keep to

the forefront of our thinking about treating mental disability that a negative view of self, which is the result of a destructive or negative spiritual belief system, can make all efforts at rehabilitation fail unless actively addressed and overcome in the therapeutic process. All of our clients come to us with more destructive aspects in their spiritual belief system (or concept of self) than constructive aspects, so this must be addressed in our treatment planning for them.

3. Treatment/Rehabilitation of Disabilities

Having identified the client'a areas of mental disabilities (through the Intake Process, in the case of most adults, and through the Initial Intervention Process, in the case of the adolescent population) we move to our approach to treating those disabilities.

Treatment is an amalgam of the approaches of the two disciplines of psychiatry and psychiatric social work. The primary training of our psychiatrists has been psychoanalytically oriented psychotherapy, but with other influences added. Therefore, the psychiatric approach at HICS, in practice, is eclectic. The social work discipline provides the systems-approach to psychotherapy so that the individual is not dealt with as an isolated entity, but rather is viewed as functioning as part of a system. This amalgam makes for a holistic approach to mental health rehabilitation. Each discipline teaches the other continuously.

Engagement of the client is the primary task of treatment/rehabilitation. No matter what else is going on, the client is trying to find out if he can trust the therapist. He has doubts, but he wants to be involved in the world about him. (The chronically dysfunctional no longer want to be involved in the world around them and have established a wall around themselves making the issue of trust irrelevant to them). For the therapist to begin to establish trust in the relationship, he must not be too passive or too neutral lest the client interpret such passivity as rejection. In other words, therapy which is initiated with Intake/Initial Intervention must be active, but not controlling.

Trust is the equivalent of enzymes in biological systems. It makes all other maneuvers with the client possible. Lack of trust makes all activity useless. Therefore, after beginning the establishment of trust, constant attention must be given to further elevating the level of trust and to maintaining as high a level of trust as possible. Obviously, if the therapist is from a familiar background, it is much easier to develop and maintain the level of trust necessary to gradually overcome the client's lack of trust.

The client who learns to trust the therapist can believe and incorporate into himself the therapist's positive attitude about him, i.e., the therapist's faith that he can function adequately to meet his physical, emotional, intellectual and spiritual needs. Trust establishes the bridges to increasingly positive attitudes about self (reversing the destructive negative spiritual outlook) and to increasingly positive activities in pursuit of one's goals.

In technical terms, we are constantly on the lookout for evidences of negative transference and negative countertransference in the client/therapist relationship so that these can be counteracted. Negative transference and

countertransference undermine trust which is all important, but labile. Therefore a great deal of supervision of therapists is necessary to establish and maintain as much stability in the area of trust as possible.

A great number of our clients, adults and adolescents, have much trouble in organizing themselves in all areas. They are prone, because of their disabilities, to be over-reactive to stimuli from the environment using little or no reflection to aid in a more organized and rational outcome. A large part of the task of treatment/rehabilitation is to help them to develop and practice techniques that will eventuate in better organization and in more rational behavior. To effect this, much time is spent teaching cause and effect relationships based on the content of what the client has brought into the treatment situation himself. In other words, this teaching about cause and effect is quite concrete, not abstract. It is kept close to the physical and emotional dimensions because the client is most closely related to these more elementary dimensions than to the mental and spiritual.

A great deal of the disorganization is related to lifestyles, but large portions are related to brain dysfunction (minimal brain dysfunction is one of the contributing etiologic factors in mental disabilities). Brain dysfunction may be partially treated by the use of various medications, but primarily by structuring therapeutic sessions and helping clients to establish specific schedules in important areas of life functioning, e.g., management of household responsibilities, child-related responsibilities, work-related responsibilities, etc.

The treatment process promotes the development of what is lacking or in short supply in the client's repertory of attitudes and skills for coping with his environment. The most important of these attitudes and skills are:

1. Trust in others and in self.
2. Faith in positive outcomes for one's endeavors.
3. Organizational skills.

This focuses us back to the critical importance in our treatment/rehabilitation efforts of the psychospiritual approach. Both one and two above are nurtured into a functional capacity for the client's regular use by the psychospiritual approach to therapy, i.e., by the therapist's instilling in the client that he <u>is</u> capable and has the <u>strength</u> to affect his life positively in whatever direction he wishes.

We stress that the relationship is the important factor in rehabilitation of the mentally disabled. Other things may be done like referral to special education or vocational training, but these cannot be approached successfully without the faith in self developed from the treatment relationship.

SUMMATION

1. We placed the mentally ill into two categories: a) the functional; b) the dysfunctional.

2. We raised serious doubts about any possibility of treating/rehabilitating the dysfunctional category. Treatment is conceived of as restoring functions and, in the case of the dysfunctionally mentally ill person, there has most likely never existed a functional capacity or it has atrophied from years of disuse.

3. We described two subcategories of functionally mentally ill persons: a) those currently functioning in the community in spite of mental disability; b) those who have functioned until recently (up to one - two years) and, therefore, present a recent history of having functioned in the community.

4. We described a program (HICS) where treatment/rehabilitation services are being provided successfully to functionally mentally ill persons.

5. We described HICS' process for evaluating the disabilities to be treated and, in the case of many of the adolescent clients, we described the necessity to train them and their families to the value of the rehabilitation process and <u>how</u> to participate in the process.

6. We described the primary factors in the rehabilitation/treatment process: a) viewing the client as functioning in a network of systems; b) using a treatment approach that is an amalgam of the disciplines of psychiatry and psychiatric social work; c) using a psychospiritual approach to overcome distrust, hopelessness and generally negative expectations of self and others; d) focusing on developing organizational skills for all areas of functioning.

EXCERPTS OF REVIEWS AND COMMENTS

The following are excerpts of reviews, comments and questions raised by the Switzer Fellows. These are presented to further stimulate thinking as well as action as it relates to the content of the paper by Dr. McKinney and Ms. Dennard.

"The Harlem Interfaith presentation, in my opinion, was loaded with areas of concern and how-to-succeed techniques which may not be obvious to those serving middle class and upper class populations. However, in view of our need to concentrate on the unserved and underserved, this particular presentation would seem to be extremely important and worthy of any efforts which we will be able to offer to facilitate its dissemination. To the broadest possible audience with particular attention to those agents or agencies that are charged with the responsibility of serving the unserved and underserved, i.e. minorities, children and young adults, migrant laborers and those populations that do not fit very conveniently into the conventional mold."

-- James E. Ramseur, M.A.

"The issue needing further discussion is the influence of culture on the rehabilitation process. Of particular importance is the impact of differences between the client and the rest of the system.

As far as implications for research it would be of considerable interest to determine if the ideology conveyed in this paper had a more lasting impact on services to members of one cultural/ethnic group than another. For example, do expressions of high positive regard on the part of therapists facilitate and expedite rehabilitation efforts? Are these attitudes more prevalent among members of similar cultural/ethnic groups?

This paper also suggests some program guidelines of import. The criteria suggested for hiring staff are particularly relevant. Staff at all levels must have a high regard for their clients and an understanding of the culture out of which they come. It is also critical that we use these criteria in our employment process."

-- Robert J. Grantham, Ph.D.

"This paper took a frank approach in pinpointing the population to which rehabilitation efforts should be addressed. However, I do not feel that the dysfunctional group should be written off."

-- Luther D. Robinson, M.D.

"On a positive note, I was impressed by several aspects of the HICS program, to include 1) focus on developing the strengths and assets of clients along with emphasis on personal responsibility for one's behavior; 2) sensitivity

to cultural and ethnic factors in service delivery; 3) apparently vigorous effort to 'engage' the client in the rehabilitation process through rapid intake and early intervention, including the attempt to make the rehabilitation process meaningful and understandable in response to individual needs; 4) emphasis on teaching personal and social skills requisite to more effective functioning and coping within one's environment; and 5) the eclectic and holistic approach to working with clients and their significant others. Taken together, the factors constitute a sound rehabilitation program."

-- John Pelletier, M.A., CRC

"This thesis of the authors is again clearly enunciated at the end of this paper when it is stated that relationships are the important factor in rehabilitation of the mentally disabled and that other things can be done such as referrals to vocational training but, to quote, 'these cannot be approached successfully without the faith in self developed from the treatment relationship.' It was stressed that clients must learn to understand the need to look back.

This reviewer believes that opportunities to develop new learning skills, have social, vocational and adequate housing, discover hidden potentials and to develop faith in one's self based on one's own experience in the present is what will bring the 'dysfunctional' to a 'functional' level. The work of Fountain House in New York, Places for People in St. Louis, and other such programs have succeeded in putting the clients' needs first and then building a therapeutic rehabilitative atmosphere where persons can move toward greater self-sufficiency. These programs show that rehabilitation of the so-called 'dysfunctional' does work."

-- Robert M. Ray, M.A.

CHAPTER FIVE

REDUCING DISINCENTIVES AND FOSTERING THE REHABILITATION PROCESS: AN EXISTING MODEL PROGRAM

AUTHOR: MARSHALL RUBIN, ACSW

SUMMARY OF PAPER

This paper gives a detailed account of an actual program that is effectively reducing disincentives and fostering the rehabilitation process. Fellowship House moves one step beyond being the comprehensive "psycho-social rehabilitation center" as it becomes a "settlement house" or community center that strives toward "normalization." Fellowship House is presented as an example of the community support program core service agency that meets the comprehensiveness of the new NIMH program. Through a detailed description of intake/outreach, direct service provision, case management and community organization efforts, Fellowship House shows how it reduces the disincentives to rehabilitation and in doing so fosters the rehabilitation process for members who are full participants with staff in all these areas. The work being done by this successful model program has tremendous relevance to the implications for research, policy and program development, service delivery, training of personnel and legislation that should be further examined so that this local and state effort can be used throughout the country.

-- Robert D. Ray

INTRODUCTION

The focus of this paper will be to identify, from the viewpoint of a service agency, the variety of processes, attitudes and conditions that can function as disincentives to the rehabilitation process. The development of Fellowship House, its philosophy, and operation within the broad community and Health and Welfare service system will be discussed and related to the central theme of this paper.

FROM PSYCHOSOCIAL REHABILITATION CENTER TO SETTLEMENT HOUSE

Fellowship House began in May of 1973 as what has been referred to in the literature as a "psychosocial rehabilitation center". Fellowship House is a private, non-profit social agency governed by its own Board of Directors. Glasscote, et. al., give a good description of the major agencies that referred to themselves in this way.[1] In general, they can be characterized as: Free standing, non-profit private social agencies; non-medical in orientation, although most have psychiatric consultants; serving solely the severely psychia-

trically disabled whose usage is voluntary (primarily a chronic schizophrenic population); deriving income from a mix of funding sources and major service offerings being vocational, social and some residential. Dincin gives a fine overview of the predominant similarities and differences of the thirteen major psychosocial rehabilitation centers (including Fellowship House) that existed in 1975.[2] The first of these centers, Fountain House, was founded in New York City in 1948.

Increasingly, I have more comfortably referred to Fellowship House as a "settlement house", which I feel broadens the agency purposes and strengthens our community identification. One of our guiding principles is to strive toward "normalization". That is, our services should be delivered in a manner that is consistent with culturally normative methods and settings, reduce stigma and create roles for members that are consistent with adult functioning in the community. The title "psychosocial rehabilitation center" carries a stigma with it. It is much easier to identify as a member of Fellowship House and thus achieve a little more distance from one's patient status. By moving away from using the former identification and adopting an image of "settlement house" or community center, I feel we are minimizing an identifying disincentive.

I wish to spend just a little time talking about the "Settlement House Movement", as I feel that concept sheds light on the thrust of Fellowship House and the process of identifying and reducing disincentives to foster the rehabilitation process. Settlement houses and settlement workers preceded the formalization of Social Work as a profession. The Settlement House Movement coincided with a shift by charity organizations in the late 1800's and early 1900's from a philosophy of "alms to the worthy" to "helping people to help themselves" (Wilson, 1976.)[3] These settlement houses were a response to assist large numbers of new immigrants in making the adjustment to and become functioning members of their new communities. Often they were organized on a nationality or other ethnic basis and so became communities of special interest within the larger society. Persons leaving mental institutions can be thought of in much the same manner as the new immigrants of the late 19th and early 20th centuries. Both have had to face an initial community response of "they are different, who needs them, send them back". Fortunately, the settlement house response was "we need and want you, come join us".

The settlement houses gave direct help with housing, food, job development, language skills, assisted in getting medical and legal services and organized their members (both the advantaged older settlers and the newer more disadvantaged) to advocate around social issues faced by their constituency. The thrust of settlement house activity can be thought of as a "movement". Webster defines movement as: "A series of organized activities by people working concertedly toward some goal; often called <u>the movement</u> by those involved in it." This usually entails a strong emotional involvement by those most closely associated with "the movement". How different is this really from the roles that Fellowship House should take on in dealing with the variety of service, organizational and social issue tasks that must be faced if deinstitutionalization is dealt with in a manner that fosters rehabilitation and maximizes community adjustment? Landy speaks of the rehabilitation process as one of acculturation.[4] This is surely what the settlement house movement dealt with, while at the same time

strengthening the identity of their constituency as a legitimate and vital part of the larger community.

I find it very interesting and pertinent that, in a discussion of Jane Addams, the founder of Hull House, an early settlement house in Chicago, Falck comments:

> "I can find nothing in Jane Addams that characterized the people whom she led as sick or pathological, needing a clinical kind of help." 5

Fellowship House philosophy can thus be compared to a settlement house in five major ways:

1. Members are viewed as needed citizens.

2. Prime attention is given to creating opportunities for members.

3. Community organization and advocacy to gain rights and access to opportunities is a major function.

4. Members are active participants in the service delivery and development.

5. Fellowship House is not a treatment facility, but rather helps its members gain access to medical resources to meet their needs. A major focus is to help members view themselves predominantly in the healthy roles of friend, worker, roommate, etc. rather than as patient.

FELLOWSHIP HOUSE AS A "CORE SERVICE AGENCY" OF A COMMUNITY SUPPORT PROGRAM

In the first six years since its inception, Fellowship House has evolved to take on the broader function of what is described as a "core service agency" for the new Community Support Program (CSP) initiated by the National Institute of Mental Health. A CSP is defined as: "A network of caring and responsible people committed to assisting a vulnerable population to meet their needs and develop their potentials without being necessarily isolated or excluded from the community.[6] (P. 329).

The 1977 National Institute of Mental Health guidelines for the CSP demonstration effort define the target population as: "Adults with a severe or persistent mental or emotional disorder that seriously limits their functional capacities relative to primary aspects of daily living, such as personal relations, living arrangements, work, recreation, etc. While many elderly persons are included in this definition, the problems of nursing homes and of the elderly per se, are outside the scope of the program." The NIMH guidelines go on to prescribe a "core service agency" as necessary to a CSP. They define the "core service agency" as follows:

> "There must be a 'core service agency' within the community that is committed to helping severely mentally disabled people improve

their lives. Frequently, this agency will itself provide a number of the basic CSP components, such as psychosocial rehabilitation services and indefinite duration supportive services. Regardless of how many direct services the core agency provides, it must take responsibility for the following integrative functions without which the clients who are most severely disabled will easily become isolated from the community:

--providing a staff who enjoy working with severely disabled people, and who are skilled in helping them develop their potential;
--offering a therapeutic community milieu in which rehabilitation and supportive services can be provided;
--helping those clients who lack meaningful community ties to make friends, and encouraging clients to help one another;
--providing or stimulating others in the community to provide opportunities for clients to assume and adjust to normal social roles, such as resident, worker, club members, etc."

It is stressed that many types of organizations could assume the "core service agency" role. Part of the CSP project nationally is to study the effectiveness of different types of agencies in assuming this role. Whatever type agency is designated as the "core service agency", their role is to assume leadership for improving services for the target population group. The CSP guidelines list ten essential services that comprise a CSP, some of which are provided directly by the "core service agency" and some which that agency takes the lead in organizing or nurturing to develop, and thus become more accessible to the target population of their community. The ten components are listed by Turner and Tenhoor.[6] (Pages 329-330).

1. Identification of the target population at risk, whether in hospitals or in the community, and outreach to offer appropriate services to those willing to participate.

2. Assist in applying for entitlements.

3. Crisis stabilization services in the least restrictive setting possible with hospitalization available when other options are insufficient.

4. Psychosocial rehabilitation services.

5. Supportive services of indefinite duration, including supportive living and working arrangements, and other such services for as long as they are needed.

6. Medical and mental health care.

7. Backup support to families, friends and community members.

8. Involvement of concerned community members in planning and offering housing or working opportunities.

9. Protection of client rights, both in hospitals and in the community.

10. Case management, to ensure continuous availability of appropriate forms of assistance.

Fellowship House, as a "core service agency", seeks to make the ten CSP services available through one or more of the following four methods:

A. Intake/outreach by Fellowship House staff and members.
B. Direct provision of services.
C. Ongoing case management intervention and advocacy.
D. Community organization efforts.

Fellowship House directly provides service to our members in four major ways: Socially, residentially, vocationally and by being advocates and primary case managers for our members moving through a mental health and social welfare system, where often one can get lost trying to find various services at different addresses. Our goal is to improve the members' quality of life and to help them reach their highest level of functioning. All people need friends, a place to stay and something worthwhile to do during the day. For some, Fellowship House is a lifetime support system. For others, it is a portion of their lives--a place to get started again. For all, it can be a place to return to from time to time, to share good news and to obtain help during life crises. Membership in Fellowship House, like a good family or community center, is lifetime.

CONVERGENCE OF REHABILITATION SERVICES ADMINISTRATION (RSA) AND NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) PHILOSOPHIES AND GOALS

During the last decade, NIMH and RSA policies reflecting funding and service delivery to the chronic population have shown changes that can potentially be very supportive of deinstitutionalization efforts that are taking place nationwide. Three important realizations are:

1. The chronic psychiatric population needs long term availability of supportive services. This has not been a priority by Community Mental Health Centers over the last decade.

2. Funding to support necessary services for the chronic psychiatric population cannot be the responsibility of any one agency alone.

3. Rehabilitative services for the chronic psychiatric population must go beyond those who have clear vocational goals.

In regard to the issue of long term services, the ten components of a CSP include, as separate entities, Number 4, Psychosocial rehabilitation services, and Number 5, Supportive services of indefinite duration. Since writing the guidelines, CSP staff have tended to view these two components as continuous, placing great emphasis on providing opportunities for recipients of service to avail themselves of a continuity of service, depending on their individual needs. The thrust of the CSP development is thus very consistent with what Olshansky described as "The Myth of Transitionalism". He wrote:

"One of the misperceptions is that many ex-patients require a network of transitional facilities within the community to restore

them to normal participation in the labor market. Some of the transitional facilities considered necessary are sheltered workshops, social clubs, and halfway houses.

"Now, I would not deny that a part (perhaps 25 percent) of this visible group might derive some benefit from such transitional facilities. However, I would insist, on the basis of the available, though limited, evidence, that it is only a small part.

By far the largest part of this visible group required these facilities not as transitional, but as long-term, facilities that would permit many of them to stay out of the hospital, or to improve their performance while in the community." 7 (P. 372).

These conclusions were more recently supported by Test and Stein (1978) in their review of research on community treatment of the chronic patient. They state:

"Modest gains in psychosocial functioning in the community can be achieved, then, through direct and intensive intervention in specific activities of daily living in the community with gains being sustained as long as treatment lasts. While such results might certainly be labeled tautological, they may also tell us something about chronic mental illness and the best methods for intervention. That is, chronic mental illness may be a lifelong disability that requires lifelong supports and direct and ongoing interventions if maintenance of improvement is to occur."8 (P. 360).

In regard to the second point, it is only recently that there has been a shift toward coordinating efforts and funding for the psychiatrically disabled. Sharfstein and Clark (1978) wrote:

"Prior to the deinstitutionalization of the chronic mental patient, care funding policy consisted of the investment in large State and county mental hospitals. Total asylums gave total care for years and lifetimes--including medical care, social services, and shelter--and as such represented a policy of 'economies of scale.' Since 1955 and the advent of medicines that control symptomatology, community mental health and deinstitutionalization have led to a new funding policy of 'let the other person (or agency) pay' and increasing fragmentation of the funding and delivery system." 9

This philosophy of "let the other agency pay" has led to a lack of coordination of funding. The categorical nature of public funding to meet the multitude of needs of this highly vulnerable population causes professionals great difficulty in negotiating the separate eligibility rules for each entitlement. Several government studies have documented the non-system of policies and funding to accomplish this. The most notable was the Government Accounting Office (GAO) report in 1977. This report showed that:

"At least 135 Federal programs, operated by eleven major departments and agencies, have either a direct or indirect impact on the mentally disabled. An estimated eighty-nine are operated by the

Department of Health, Education and Welfare (HEW). Almost every component agency within HEW has programs which affect the mentally disabled. Other Federal agencies include ACTION and the Departments of Labor, Justice, and Housing and Urban Development (HUD)." [10] (P. 5)

The GAO report states further that "Under these Federal programs, almost every type of service needed by mentally disabled persons in communities can be financed wholly or partly with Federal funds". However, often the funds are not used, as many agency representatives at Federal, State and local levels are not even aware of the deinstitutionalization goals or how they can foster it, because there is no overall plan or management system to direct and coordinate deinstitutionalization. This was the case with Housing and Urban Development funds until the CSP staff took a leadership role and worked with HUD officials to make HUD funds accessible for use by the chronic psychiatric population.

Deinstitutionalization of the mentally disabled has been a national goal since 1963 with the advent of Federal legislation creating Community Mental Health Centers. However, although these mental health centers were given the task to work with the severely psychiatrically disabled, funding for rehabilitation was one of the five non-mandatory services. Therefore, what services did develop for the chronic patient, with few exceptions, were Aftercare and Partial Hospitalization oriented Day Treatment on a limited basis. Both of these services were clinical and medical model oriented. It seemed that the professionals operating the mental health centers not only were not given the resources to develop rehabilitation services, but were more inclined to think in terms of transitional, treatment oriented services for this population. A survey done by Rubin and Lotz (1975)[11] in Florida shows that, when mental health center administrators were given an option of ranking in importance five services (Psycho-therapy, Day Treatment, Residential, Vocational Rehabilitation, and Social Club) for the adult chronic patient on a long-term and transitional basis, they ranked Vocational Rehabilitation sixth and seventh and Social Club ninth and tenth. Residential, Psycho-therapy and Day Treatment received the highest rankings. With this attitude, it is no wonder that rehabilitation services and strong partnerships with State Vocational Rehabilitation authorities have not developed within community mental health centers.

The Community Mental Health Center Amendments of 1975 (Public Law 94-63) still did not place on emphasis on long-term rehabilitation services. In fact, rehabilitation was deleted as one of the possible services and transitional services--mainly residential in nature--were added to the new mandated services.

However, there now seems to be hope as a result of the 1978 President's Commission on Mental Health which strongly cites the CSP effort and places a priority on long-term services to the chronic mentally ill. This recommendation has been incorporated into the Administration Proposal for a new Mental Health Systems Act. Hopefully, we should soon begin to see a change in planning with more funds going to mental health centers and other agencies that are ready to give priority to the chronic patient.

In regard to the third point, there has been a growing recognition by rehabilitation authorities that the chronically disabled rehabilitative needs are broader than just vocational and, if vocational growth is to be achieved,

there are other rehabilitative tasks that must be given attention. Mary Switzer, to whose memory this seminar is dedicated, expressed the growth of the philosophy of rehabilitation quite well in a 1964 statement:

> "Vocational rehabilitation, like many other aspects of human affairs, has evolved through three stages of public attitudes--compassion without action, followed by willingness to act for economic reasons, followed by willingness to act for social reasons. It seems to me that we are at a transitional state between the last two, with almost universal acceptance of the economic soundness of returning disabled people to employment and a slowly growing philosophy that an advanced civilization like ours should so order its systems that all disabled people will be restored as fully as possible, regardless of any economic benefits to anyone."[1] (P. 28).

This enlightened statement was made fifteen years ago. Since then, the policy of the rehabilitation authority has seen a gradual shift in the direction Mary Switzer inferred. Specific landmarks were:

(a) In 1967, the word "vocational" was dropped when the name of the Federal agency was changed to Social and Rehabilitation Service (later to Rehabilitative Services Administration).

(b) In 1973, the Vocational Rehabilitation Act placed a priority on service to the severely disabled. The chronic psychiatric population being one of those groups was eligible, but at the discretion of each state.

(c) The Comprehensive Rehabilitation Services Amendments of 1978 strengthened potential funding for the severely mentally disabled by:

-stating clearly that RSA had a responsibility to meet the vocational needs of the severely mentally disabled.

-RSA's responsibility was extended even to those without a clear potential for independent competitive employment.

-States have the option to establish "Centers for Independent Living". Funding for this is pending, but the mandate for RSA funding non-vocational rehabilitation services has now been established.

(d) Under the leadership of the CSP staff, a NIMH/RSA Cooperative Agreement was signed in May of 1978. That agreement paved the way for establishment of formalized working relations on the State and local levels. A first project of this agreement was the funding of a Research and Training Center for the rehabilitation of mentally handicapped individuals. This center will not limit its research to vocational aspects of rehabilitation.

The importance of the CSP effort cannot be over-emphasized. At the Federal level, CSP staff have worked closely with HUD, RSA and ACTION to coordinate efforts on behalf of the psychiatrically disabled. On the State level, similar

coordinating efforts to maximize planning and entitlements for this population are undertaken. (There are now twenty NIMH funded state CSP projects). At the local level, demonstration sites will attempt to actualize the efforts of the Federal and State planners into coordinated and comprehensive service that will maximize time out of hospitals, increase productive activity of the psychiatrically disabled and improve the quality of life for the psychiatrically disabled.

All these trends are positive ones. They allow service agencies to plan for more comprehensive, coordinated, long-term service availability and thus reduce institutional and policy disincentives to rehabilitation.

HOW FELLOWSHIP HOUSE REDUCES DISINCENTIVES TO REHABILITATION

Having discussed the broad Fellowship House philosophy, the CSP movement, and the positive convergence of RSA and NIMH policies in relation to the chronic mentally ill, I will now discuss how Fellowship House organizes its services to minimize disincentives to rehabilitation.

The format I will follow will be to discuss minimizing disincentives from the framework of the four methods mentioned earlier, by which Fellowship House, as a core service agency, addresses the ten CSP tasks. These are:

A. Intake/outreach by Fellowship House staff and members.
B. Direct provision of services.
C. Ongoing case management intervention and advocacy.
D. Community organization efforts.

A. INTAKE/OUTREACH BY FELLOWSHIP HOUSE STAFF AND MEMBERS--ENCOURAGING INVOLVEMENT.

The initial contact a potential member has with Fellowship House may well determine whether the individual will get involved in service or drop out. A study by Sue, McKinney and Allen (1976) showed that:

> "Of 13,450 clients seen in approximately twenty community mental health facilities, 40 percent terminated treatment after only one session."[12]

Therefore, the first task that Fellowship House has in reducing disincentives is to encourage members to join. We must overcome the negative attitude they have developed as a result of past experiences with social agencies and hospitals that put them through repetitive diagnostic and eligibility interviews. The thrust of the Fellowship House intake process is to establish relationships, which is one of the main difficulties of the chronic schizophrenic population we serve. We attempt to do so in the following manner:

1. Approach the intake situation with an attitude of screening in rather than screening out.

2. Convey a message that they are "needed members" rather than patients or clients.

3. Our current members host, tour, and explain program to prospective new members. This resembles a "Welcome Wagon" approach. Membership cards are given out and the benefits available to members are explained.

4. We hold orientation groups on days that social program is happening so that prospective members can stay for lunch and afternoon social program.

5. We have begun a pre-discharge program at the State hospital, operating out of borrowed space from the Office of Vocational Rehabilitation. Thus, the Fellowship House Intake staff involve themselves in case finding and disposition planning with OVR and hospital staff. Also, prospective members can attend a Fellowship House center, which is located ten minutes from the State hospital, on a daily basis for three to four weeks prior to discharge from the hospital. Intake staff maintain regular liaison relationships with other major referring agencies.

6. Regular outreach is done jointly by staff and members to board and care homes to attempt to form relationships with prospective new members.

7. An Affirmative Action approach is incorporated into the intake/outreach efforts, as Fellowship House has underserved four populations: Blacks, Hispanics, women and persons over the age of thirty-five. Intake staff, and members who work along with them, are consciously hired and recruited to maintain an ethnic, sex and age balance. The Fellowship House intake staff will involve State hospital staff in developing an Affirmative Action plan for the pre-discharge program. This is important as the Affirmative Action target population can be more easily identified while they are still at the hospital. We hope to attract more senior members via a new project funded by ACTION, which will allow for the hiring of five senior citizens as "Senior Companions" to assist Intake staff at Fellowship House and in outreach efforts at boarding homes and the State hospital. Priority for hiring will be given to current Fellowship House members who are sixty (60) years of age and older and to making this team tri-ethnic.

8. The Intake staff and members work together to reach out to members who drop out or fail to show for a first appointment.

9. Intake staff and members are planning an ongoing videotape orientation service for new members to more fully expose them to program opportunities and purposes of Fellowship House. This is based on positive findings of a Fountain House study indicating that those members who participated in the videotape orientations made greater usage of the Fountain House program. 13 (1977).

10. Intake staff assist prospective members to obtain resources for decent housing, food and other necessities. When this is accomplished expeditiously and in a manner that communicates the individual's rights to these benefits, disincentives to involvement are minimized. Also, old members take an active role in helping new members apply for entitlements when procedures have been established, such as escorting new members to the Food Stamp Office.

In summary, intake staff and old members who assist in the orientation process play an important role in setting a tone that Fellowship House is an "O.K." place to belong. The attitude that must be conveyed is similar to that given by a settlement house--"You are now a citizen and you are entitled."

B. MAKING DIRECT SERVICES ATTRACTIVE

The direct service efforts of Fellowship House coincide with what CSP lists as tasks number four and five--Psychosocial Rehabilitation Services, and Supportive Services of an Indefinite Duration. As mentioned earlier, Fellowship House makes no distinction between these services. There are no time limits and we make no attempt to try to predict who will be successful and who will not. Our strong belief is that communities are made up of individuals with varying skills and each has something to contribute. To segregate would make it impossible to create an atmosphere of normalization and dignity. To try to segregate individuals into "fast" and "slow" would impede the ability of members to help and learn from each other while creating a self-fulfilling prophecy of failure for those designated as less likely to succeed.

The Fellowship House program is designed to create opportunities for members socially, vocationally and residentially. Members may take advantage of any combination of services. Program offerings are designed so that members can utilize them based on their changing needs. It is also important to point out that program involvement is not sequential. Fellowship House does not believe that rehabilitation happens in a sequential manner. Fellowship House seeks to respond to members' needs as they occur. To set up rigid steps for program involvement would be a disincentive to developing relationships.

Maximizing Social Opportunities - The total Fellowship House program is established on the basis that social skills are part of all human tasks. Thus, our effort in helping members succeed in work and residential opportunities is done in a manner that strengthens the interpersonal skills associated with work and living as independently as possible. However, we realize that an important part of the support system for all human beings is to have the opportunity for healthy leisure experiences. This happens in the Fellowship House social program.

The Fellowship House social program is operated as a community center. The community center concept, itself, developed from the settlement house movement. To belong to a community center is an adult and normal role. In a Fellowship House video training tape, Treuer (1978) enumerates seven purposes of the Fellowship House social program. She states that each of the purposes has a duality of function: "First, to create and maintain our own community at Fellowship House community."[14] These seven purposes, and some ways they are attained are:

1. To break the cycle of social isolation and rehospitalization. Staff and members consciously welcome new members and reach out to old members who do not attend. We hold regular community center hours. It is normal to socialize in the evenings, holidays and weekends. Having a dance on a Tuesday afternoon is stigmatizing and a disincentive to rehabilitation. We create many types of activity groups where members can take on different roles and responsibilities. We all need alternatives to choose from and

get tired of doing the same thing. We make our community center comfortable and attractive. If the club is set up attractively, a sense of dignity is conveyed and members will take pride and maintain their center.

2. To improve social skills of members and learn new ones. Staff, volunteers, and other members serve as role models. We consciously try to recruit staff and volunteers to represent a wide range of ethnicity, age and both sexes, so that there is a variety or role models to learn from and with which to identify.

   We intervene openly when inappropriate behavior and behavior that deserves recognition occurs, so that members get direct feedback and others can learn by example. The message is given neither hostilely nor solicitously, but with normal human concern. Also, members are encouraged to give feedback to each other openly as their concerns are valid ones and Fellowship House is their community center.

   Conversational groups are held on topics of interest to members. These are not therapy groups, but give members an opportunity to express their views.

3. To help members learn how to relax and enjoy themselves. We set an atmosphere of busy but not boring. There is always a variety of things to do. We are not unstructured, but there is flexibility. Some persons participate by watching. A busy atmosphere sets an expectation of not dwelling on problems. Too many people think "I can't enjoy myself--I have too much to worry about."

   Staff and volunteers role model how to enjoy leisure. We need to present what is enjoyable about given experiences by verbalizing and pointing out what is fun or interesting, much in the same way a tour guide does with tourists.

4. To maximize the potential of each member. We offer opportunities for individual private efforts through hobby activity and opportunities for efforts before an audience through group participation and leadership. There is a lot of work connected with social program. Members create posters, work on planning committees, cook, etc. However, because it is fun, it doesn't feel like work.

5. To help members become more self-directed in their interactions with others. Within social program, there are a lot of opportunities for individual decision making--How to use one's free time, when to come, what to do and with whom to do it. There are a lot of options and types of people to relate to. Also, there are decisions to make regarding what roles to get into. An individual may choose to be part of planning on one night and be a cook for a potluck supper another night. This gives the opportunity to find satisfaction from different roles and find out how others relate to you in different roles.

6. To create a long-term support system. The social program at Fellowship House is a major part of the long-term support system that maintains a sense of belonging. Fellowship House is never closed. On holidays, there

is always a planned program. Celebrating holidays is for real and held on the right day. Family, friends, members and staff are all welcome. When planning programs, we attempt to maintain tradition without staleness. It is important to strike a balance of keeping popular programs similar, yet creatively different. Members look forward to traditional activities, but programs must always grow. As the Fellowship House community matures, more traditions are added.

7. To introduce members to community resources. This is done through guest speakers and performers who are invited and treated as house guests. Field trips to community activities are planned each week. Since members' resources are limited, events are planned that can be afforded on a limited budget so that members can return on their own or with friends.

In summary, we at Fellowship House view our social program as a valuable resource. Members are encouraged to maintain the real friendships and good experiences they have at the Fellowship House community center. Activities that are offered are not therapy oriented, but geared to normal adult interests and enjoyment. For instance, drama interests are nurtured by offering a drama club, not "role playing" or "drama therapy". As in any good community center, one does not outgrow it, but rather one becomes a part of it and it becomes a part of you. The Fellowship House social programs have become "the place to go" rather than a place to go when there is nothing else to do. Therefore, active involvement is not a disincentive to rehabilitation, but an indication that rehabilitation is happening.

MAXIMIZING VOCATIONAL OPPORTUNITIES

The Fellowship House approach to vocational rehabilitation is twofold. First, Fellowship House operates two clubhouses: our original main building in the southern part of our services district and a new smaller one in the northern sector. This new center was established to make services more accessible, which in itself helps reduce a disincentive to involvement. During the daytime, members who attend are involved in needed productive activity. Feeling needed is healthy. The daytime vocationally oriented program helps members develop skills needed in every job situation. Members and staff work side by side at the job of running Fellowship House. The staff are not just job supervisors, but active participants. In the work activity milieu, staff are also case managers, helping members with their problems and facilitating getting needs met. The focus is on helping members feel useful by mutual participation and the taking on of responsibility at Fellowship House. Members prepare food, publish a daily newspaper and video news show, collect data and prepare reports. Members also clean and repair the furnishings and maintain the landscaping. New tasks are always being developed as the needs of Fellowship House change. The focus is on helping members develop relationships with Fellowship House via feelings of being involved and productive. This relationship can enable a member to move on to Transitional Employment and/or competitive employment. For those members who do not have employment goals, being allowed to continue to be productive in their clubhouse is important to maintaining a needed citizen image.

Transitional Employment is the second part of the vocational rehabilitation approach at Fellowship House and is modeled after the very successful program

first developed by Fountain House of New York. Over the last three years, Fountain House has run a national training program for staff developing community based services for the chronic psychiatric patient. A major emphasis has been on training to develop transitional employment. As of the Fall of 1979, 955 members of 67 different psychiatric rehabilitation facilities participate in transitional employment involving 361 employers. Their annual earnings are reported at the rate of three and one-half million dollars.

Transitional Employment is an employer-paid program designed to meet both employers' needs for productivity and members' needs for successful work experience. The fact that it is totally employer paid, rather than partly government financed, acts as an incentive for member, staff and employer. Real wages are paid only for real work. Entry level positions are sought by Fellowship House throughout the community and Fellowship House agrees to fill one or more positions at an employer's firm. Members work half-time and full-time jobs are filled by two members. Fellowship House guarantees performance of the job to the employer in several ways. First, we evaluate the position and have a staff person train on the job for three full days, thus insuring that we understand the job requirements completely. Our staff person then trains members on the job for one or two days until all tasks are being performed competently. A member is placed on the job and a back-up member is also trained for each position. If both members are absent, our staff person reports to work. The employer gets a "total performance commitment" from Fellowship House.

Fellowship House places both individuals and groups of members in jobs. When a group of six or more members is placed, a staff person remains on the job full-time providing guidance and support at no additional cost to the employer. All members are paid at the same rates as permanent employees of the firm and must meet the employer's performance standards. Members hold the same transitional position for three to six months, after which they participate in the training of a replacement. Members receive considerable benefits from working a Transitional Employment job. The major bonus, all agree, is real pay to supplement their incomes. They also receive a reference from the employer, after successful completion of the position. It is possible for members to have as many transitional employment opportunities as they need in order to help them maximize vocational success.

The Fellowship House approach to work is very simple. We do tasks that are real and relate to the real work world. This is also similar to the settlement house movement. Their members were needed to help run the settlement house and those that needed jobs were helped to obtain them. Our message to our members is "help us run Fellowship House and we will help you get real work and real pay when you are ready to take on that responsibility."

We do not offer specific job training because there are places in the community that can do training better than we can. If training is needed, we work to have our members accepted by a good training program.

It is also important that we prioritize our tasks to allow us to respond to potential crises on Transitional Employment. Staff must be prepared to drop all other activities to go to a transitional employment site to assist a member.

This means that members are really needed to do tasks at the clubhouse so that the staff can respond quickly. In practice, this reinforces the members' importance and acts as an incentive to rehabilitation.

To maximize our ability to support members on Transitional Employment, more than one staff person must learn each job. Staff need to cover for each other during vacation or illness and when multiple crises occur. The greater our ability to respond to an employer's needs, the stronger the incentive for industry to work with us. Relationships grow over time and must constantly be nurtured to maximize opportunities. We can never take relationships for granted. This is evidenced by one group placement which has grown from six to twelve positions over three years. But, during that time, our staff had to relate to four new company managers.

IMPROVING LIVING OPPORTUNITIES

The philosophy of Fellowship House residential services is to provide the members with the best housing for their housing dollar in the least restrictive setting. We have a continuum of residential choices ranging from the highly supportive and transitional to the less supportive and long-term, possibly permanent. Our members possess different levels of living and coping skills. Their skills in these areas may be different at various points in their lifetimes. Therefore, we have three residential opportunities: (1) A group home, (2) a complex of supervised apartments, and (3) satellite apartments.

It is important that members living in any of the three options spend normal workday hours either in the Fellowship House vocationally oriented program or in productive work activities of their own. Residents are also encouraged to take advantage of the weekend and evening social program. Members' time spent in our residential facilities is focused on home management and family living activities, so that social and vocational rehabilitation activities are not conducted in the members' homes. This is consistent with the principal of normalization and, thus, is an incentive to rehabilitation. We learned to avoid what we now call the "bedroom slipper syndrome". When, at one time, our group home and vocational/social center were not separate, many members left their rooms only to eat and participate in the vocational and social programs. Too much time was spent isolated in their rooms, as they rarely ventured out of the building. In addition, we have found that, by not having "rehabilitation" activities within our group home, we were able to locate our facility without having to go through a zoning variance that would have been required for a more comprehensive facility.

Our three residential options are presented here in order of decreasing supervision. However, involvement is not necessarily sequential and members can utilize the facility which coincides with their present need.

1. Group Home (Fellowship Manor)
   Members utilize this residential program when they are most vulnerable and need a high degree of supervision and support. We have 24-hour on-premise staff supervision to help members learn living and interpersonal skills needed to live in the community and to enable a member to move into a supervised or satellite apartment.

2. Supervised Apartments

For those in need of less structure and who do not need in-house staff supervision, the supervised apartments are available. A group of four members live in each of seven apartments. A staff member lives in an apartment located in the complex and works with the members in their apartments, helping them in the areas of cooking, cleaning, bus travel, and getting along with others.

3. Satellite Apartments

The Satellite Apartment concept was first developed by Fountain House of New York. This living arrangement is for members who have the basic skills necessary for more independent living, and who can function without the need of 24-hour on-premise supervision (although "on-call" crisis help is available around the clock). Satellite apartments are leased by Fellowship House in clusters, so that a social network is formed between members living in those apartments. Since costs are shared by roommates, even people on Welfare and Social Security can afford this quality housing. Members may live in a satellite apartment as long as they maintain it, get along with their roommates and pay their bills. Apartments and apartment responsibilities are generally shared by four members. Fellowship House holds the lease and guarantees payment of rent to the landlord. This is an incentive both to the landlord and to the members who, most times, would not have references or funds necessary for a deposit. The apartments are attractively furnished from donations of furniture and household items solicited by Fellowship House. By living in a decentralized apartment, the member resides in a manner that is consistent with the surrounding community, thus minimizing any chances for stigma and community unrest.

C. ONGOING CASE MANAGEMENT INTERVENTION AND ADVOCACY

Our members all have many needs, some of which are met directly by Fellowship House and many which are met at different locations and by different agencies. The purpose of case-management is to provide the personalized help that allows members to organize their lives to meet ever changing human needs. The Fellowship House system of case-management has been established to reduce the disruptive effects that fragmented service delivery has on the lives of the chronic mentally ill we serve. Our case-management system is based on the following assumptions: (1) It is best done by the individual who has the strongest relationship with the member; (2) It is most effective when there is backup responsibility by a team of staff; (3) It is most effective when performed by an individual or team from which the individual is receiving other services.

Therefore, the Fellowship House case-management responsibilities are assigned to the individual and team with which the member has major program involvement and is done in the context of, and concurrent with, the delivery of services. For instance, plans for obtaining food stamps may be made while the member and his case manager work cleaning Fellowship House. In a sense, this is a family model. If the member is in the vocational program, the case-manager is a unit advisor in the particular unit in which that member is involved. If the member goes to work and comes only to social program, the case-management responsibility may transfer to one of the social program staff. This transfer may occur immediately or later on depending on the desires and needs of the member involved.

In summary, we agree with Talbott (1979) who wrote:

> "A case-management system must be established. Such a system should not create a whole new profession or paraprofession, but should make use of existing manpower and resources." [15]

Too often agencies have set up separate case-management systems that are more for purposes of tracking. We feel that tracking is a responsibility of case-managers, but is not the sole function. If it were, case-management would resemble a probation officer's role.

For us at Fellowship House, case-management naturally fits in with our primary task--to develop a relationship with our members that serves to maximize opportunities. This also seems most natural since a very prevalent problem of the chronic schizophrenic population is difficulty in forming interpersonal relationships. If a relationship is formed, it should be utilized. This is a way of minimizing disincentives in this task.

D. COMMUNITY ORGANIZATION EFFORTS

To achieve the comprehensiveness and continuity in service for Fellowship House members that is our goal, it has been necessary for Fellowship House to take on an increasingly active Community Organization role. This is appropriate to talk of in terms of reducing disincentives because, unless a system is comprehensive and provides for continuity, members' needs cannot be adequately met and disincentives to involvement in the rehabilitation process are increased. Fellowship House, as a "core service agency", must take on a community organization role. This is also consistent with the role played by the early settlement houses, as described by Grosser (1973):

> "Settlement experience demonstrated that the best programs were failures when appraised as measures to reduce urban pathologies. Confronted with the spector of this failure, leaders of the settlement movement were pressed to social reform, activism, lobbying, muckraking, education, and political pressure to attempt to meet the needs of the urban poor...using professional and personal skills and talents, contacts with sources of influence...in short their own resources to take action on behalf of others." [16] (P. 78)

We see Fellowship House community organization activities categorized under three main headings: (1) Resource development; (2) Planning and advocacy; and (3) Public education and promotion. These are tasks mainly performed by the administrative staff of Fellowship House and two community organizers who have been hired under our CSP contract and an Office of Vocational Rehabilitation Establishment Grant to facilitate and plan for the expansion of Fellowship House services. In the carrying out of these community organization functions, Fellowship House Board of Directors and other community groups are involved to expand the scope of influence.

RESOURCE DEVELOPMENT

No agency can exist without adequate resources. It is also important to be able to develop as broad a range of financial support as possible. This includes both private and public support. Agencies that depend on a limited scope of support are certainly more vulnerable to financial distress.

Also of crucial importance to an agency such as Fellowship House is that funding sources often prescribe the goals and nature of service. Thus, if scope of resources can be expanded, there is less limitation placed on members served. Prime examples of this are Community Mental Health Centers which predominantly have served the chronic psychiatric population only with clinical and time limited services giving little emphasis to the long-term and vocational needs of this population. The survey by Rubin and Lotz (1977)[11] of twenty-five Community Mental Health Centers and Adult Aftercare Clinics in Florida showed that agencies reported using a surprisingly small range of funding sources. At Fellowship House, we have an advantage over community mental health centers in that we have one target population to serve and towards whom all our administrative functions are devoted. Therefore, our resource development is geared to promoting comprehensiveness of service for one population rather than having to divide our energies and priorities to serve multiple populations.

Much can and has been written about resource development. To adequately cover this subject would require more space than the scope of this paper allows. What I will do is list the basic assumptions under which Fellowship House approaches this topic. These are:

1. Resource development is as much attitudinal as it is knowing lists of specific government and private funding sources. We view each contact from the standpoint of "What can this person or agency do for Fellowship House members?"

2. Resource development is a two-way street. A resource relationship must be maintained and ways found to reciprocate and give recognition.

3. Board members must be helped to see their roles as fostering resource development. To do so, they must be educated about the agency service program so they can believe in and interpret the program goals.

4. Continual resource development means accountability, both in terms of taking care to use resources appropriately and to report accurate results.

5. Do not expect one resource to cover all areas. Both government agencies and private resources have special areas of interest. Find out what they see as their mission or what their interest is and be satisfied. A sure way of turning off a resource is to try to get them to buy something they don't want or see as a priority. To fund the comprehensive and varied needs of the chronic mentally disabled means using multiple resources.

The five points listed above mean that Fellowship House must conduct itself as a good business, if we are to expand and maintain our support base.

Before leaving the topic of resource development, I want to mention that this also includes the development of income maintenance resources for the members we serve.

It is safe to say that many of the chronic mentally ill are going to need maintenance benefits over a long period of time. At best, they are intermittently employed, employed in less than full-time positions, or working at jobs that pay at, or little more than, the minimum wage. The deinstitutionalization effort is hindered by lack of adequate and consistent financial assistance to enable the chronically disabled to buy decent housing, food, and other basic necessities. It is unfortunate that, when one thinks of disincentives to rehabilitation, the first image that comes to mind is that of the malingering welfare recipient. I must state that it is time to move towards a social policy that does not remove basic health and welfare benefits when disabled individuals become low wage earners. To do so, we are only inviting further deterioration and rehospitalization. If we are finally willing to admit that we cannot "cure" the chronic mentally ill, we must be willing to sustain them at the highest level possible. The disincentive is not utilizing public assistance, but rather not allowing public assistance to be a supplement for disabled low income earners. Unfortunately, until public social policy changes to allow for this, the best that we can do is to maximize the number of potential maintenance resources so that scarce resources are not inappropriately utilized and the right resource is utilized at the appropriate time. For instance, emergency county welfare funds may shorten a person's stay in the hospital, but should be supplanted with S.S.I., S.S.D.I., Office of Vocational Rehabilitation maintenance funds, earned income or family assistance, as the individual becomes eligible for these other benefits. Fellowship House's relationships with all funding agencies are strengthened if we conduct ourselves in this manner and, thus, are seen as advocates, but not usurers.

Income maintenance entitlements are often difficult to access. Thus, Fellowship House community organization staff spends considerable time developing formalized agreements with agencies that control such benefits. These agreements then become the tools which case-managers utilize in helping members receive entitlements.

PLANNING AND ADVOCACY

A major community organization role for Fellowship House involved leadership in planning and advocacy. Turner and Tenhoor wrote:

> "Citizen and professional groups active in mental health generally have avoided grappling with the long-term problems of the mentally disabled, and have focused instead on issues that seem to offer more immediate rewards. CMHC advisory boards, for example, have tended to focus on broader purposes and goals of community mental health rather than to serve as advocates for the needs of the seriously mentally disabled. Thus, the root of the problems in community services for the mentally disabled may well be the lack of an organized and caring constituency to work for improvements at all levels. This suggests the need for a process to convene and nurture such a constituency - a coalition of concern - within each State and community."[6] (P. 325-326)

By virtue of Fellowship House taking on a "core service agency" role, we must take major responsibility on a local and statewide level to effect changes that will promote opportunities for the chronic psychiatric population as a priority.

Once again, space only allows a synopsis of the type of planning and advocacy tasks that Fellowship House has and will undertake. The range of tasks are:

1. To formalize linkages between Fellowship House and other local agencies so that the chronic psychiatric population can benefit from the services of each agency and avoid duplication. Examples of this are that Fellowship House members will need to rely on the treatment resources of the several Mental Health Centers in our service district and the Mental Health Centers have clients who can utilize Fellowship House services.

2. To encourage and take leadership roles with local and State Mental Health, Vocational Rehabilitation and other health service authorities in planning to meet the chronic psychiatric population needs. Examples of this were: Involvement and consultation regarding State deinstitutionalization; conducting a needs assessment that resulted in expansion of residential facilities by fifty beds with joint Federal, State and county funding and development of a pre-discharge plan involving both the State hospital and the Office of Vocational Rehabilitation.

3. To give technical assistance to other agencies on a statewide basis to develop a "core service agency" responsibility for CSP development in their communities. Fellowship House has taken on this responsibility as a result of our CSP contract and RSA grant. These projects require us to train eight to twelve agencies in different communities in the State of Florida in cooperation with their respective Mental Health and Vocational Rehabilitation District Authorities. This training is described by Beard[17] (1979).

4. To develop statewide and local organizations representing (a) Service providers, (b) Families and (c) Ex-patients who can together act as an advocacy coalition to effect State and local planning priority for the chronic psychiatrically disabled. To date, Fellowship House has been able to organize a Community Support Division under the auspices of the Florida Council for Community Mental Health which is an organization of service providers in the State of Florida. There currently exist fragmented parents' groups and ex-patient groups in one or two communities. The training role Fellowship House is playing with the eight to twelve communities allows an excellent opportunity to foster the development of these two organizations.

Mental health professionals and agencies have not availed themselves of the resources of concerned parents'organizations. These organizations, if worked with as partners, can be mutually beneficial. Lamb and Oliphant[18] sum it up well when they write:

> "As parents' groups become more powerful and politically sophisticated, professionals will be reminded more and more forcefully when they have been insensitive to the needs of the severely mentally ill and their families". (P. 85...)

"Community mental health is still in the throes of learning how to integrate consumerism and citizen advocacy in its philosophy and everyday operations. Mental health professionals should see concerned citizen groups as partners in the quest for better human services (Wolfensberger, 1972), rather than as nuisances or adversaries to professionalism generally and their agencies in particular. Though citizen groups may take issue with public and private agencies, responsible ones do not usually interfere with agency functioning unless the agency is not meeting important community needs (Moise, P. 90-91)."

We at Fellowship House need to take action in opening our doors and lend staff support to help the parents of our members to organize as a separate, but interrelated, advocacy and support group.

5. To plan effectively to help Fellowship House reach its Affirmative Action goals. As mentioned earlier, Fellowship House does not proportionately serve four segments of our population: Black, Hispanics, women, and persons over the age of thirty-five. These four target groups are also grossly under-referred. The community organization staff plays a major role in identifying and removing barriers to referral and services.

PUBLIC EDUCATION AND PROMOTION

A final community organization role is public education and promotion. It has been well documented that the lay community has many fears and misconceptions about the chronic mentally disabled. There are many opportunities to present the facts about mental illness to civic and community groups. Whenever possible, we involve our members in presentations because, together, we can do a better job. Our members also enjoy these opportunities to take on another needed role.

Often, speaking engagements lead to volunteer help, resources and result in referrals of members who otherwise would go unserved because Fellowship House was unknown to the referring agent or the symptoms were not recognized as mental illness.

We are constantly making presentations to minority group organizations with the hope of stimulating the involvement of members of these underserved populations in our program.

Community organization, educational efforts can also pave the way for acceptance of service in neighborhoods and communities where zoning is an issue.

Finally, the District Mental Health Board, Health Planning Council, District Health and Rehabilitative Services Advisory Board and Mental Health Association are all composed of lay citizens. It is a mistake to assume that, just because they are involved in planning for mental health and rehabilitative services, they are knowledgeable of, or place a priority on, the needs of the chronic psychiatric population. Fellowship House staff must be present at as many of their meetings as possible and use every opportunity to educate and increase their sense of priority for the psychiatrically disabled. The same

holds true for the County and City Commissions and other groups who have decision making power, but often exercise their power without adequate knowledge.

Education of our community is a long and never ending task. However, each time we educate another individual or group, we create a little more community acceptance. In doing so, we slowly remove barriers that, in turn, reduce disincentives to and foster the rehabilitation process.

EVALUATION

Program evaluation is an ongoing function at Fellowship House. Recently, Fellowship House has developed an evaluation protocol that is now being utilized to supply data to both our local and State Mental Health Authorities and for the National Institute of Mental Health Community Support Project. This protocol includes eight evaluative areas: (1) Prevention of hospitalization; (2) Residentail independence; (3) Quality of residential arrangements; (4) Use of community resources; (5) Independent functioning; (6) Social adjustment; (7) Work related productive activity and (8) A measure of global functioning which is derived from summary scores of the first seven areas.

It is premature to report results of the evaluation protocol at this time. However, evaluation efforts over the past two years have shown that for individuals who have maintained membership in Fellowship House, they have decreased the number of days of hospitalization by 91.7% and 89.8% for each of the two years, as compared to the year prior to their involvement at Fellowship House. Evaluation data for the last year, measuring days of paid employment, showed that individuals who availed themselves of the Fellowship House vocational program for the program year showed a 203% increase in days of paid employment over the year prior to their involvement.

This past year, Fellowship House served a total of 491 different individuals. In July of 1979, there were 336 active members of Fellowship House. Approximately 95% of Fellowship House members have had previous psychiatric hospitalizations, with the great majority having multiple hospitalizations.

Consistent with the Fellowship House philosophy to involve members in needed work activity, members assist the overall evaluation effort by collecting and compiling monitoring data, which forms the basis of the Fellowship House evaluation process.

CONCLUSION

The process of reducing disincentives and fostering the rehabilitation process for the mentally ill is a complex and challenging one. I have attempted to present, in the space allowed, the issues and complexities as we face and conceptualize them in our work at Fellowship House. I hope I have adequately conveyed not only the challenge and issues we face, but also the sense of enthusiasm that is both real and necessary to work successfully with our members.

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EXCERPTS OF REVIEWS AND COMMENTS

The following are excerpts of reviews, comments and questions raised by the Switzer Fellows. These are presented to further stimulate thinking as well as action as it relates to the content of the paper by Mr. Rubin.

"When the terms 'chronic mentally ill' and 'severely disabled' are used, who and what kind of patient is in each category, or, are these terms used interchangeably? Does 'chronic' mean always being this way or does it allow for change?

In the text the following statement is made - "If we are finally willing to admit that we cannot 'cure' the chronic mentally ill, we must be willing to sustain them at the highest level possible." Webster defines 'cure' as: a method of medical treatment; act of healing or a state of being healed; means of removal of disease or evil; a remedy; a special method or course of remedial or medicinal treatment. I find this statement giving much fuel to the old myth 'once mentally ill, always mentally ill'. I thought we were trying to educate the public to the truth that mental patients can and do get well. Maintaining one's physical and mental health is a daily process. To say we cannot 'cure' the chronic mentally ill to a patient gives a prophecy of doom and patients are very suggestible to the point of feeling hopeless which can result in their not 'trying'.

Concerning policy development, members should be represented and have full voting rights on the Board of Directors (member being one still a participant or one who has been rehabilitated); they should be represented in all program planning; develop a core of former patients to be involved in all activity as a 'peer model' to encourage and foster motivation of members. I would encourage the philosophy of 'see one', 'do one', 'teach one' which gives the member a vital opportunity to grow in self-confidence and self-respect and also of being responsible for doing something for themselves while offering something to another. Members/patients must also learn to give something of what they have received as a means of growing."

-- Nancy Downes

"The concepts presented in this paper are of paramount importance to the efficacy of psychiatric rehabilitation. The concept of the community support system, with all of its ramifications, provides a key to the 80's. It may not be that all programs become settlement houses, but the conceptual framework and philosophies are viable directions to move in. The three important realizations facing RSA and NIMH on page 4 of this paper are key legislative issues and need to be addressed as recommendations from the seminar. We also must get Congress and the President to allocate funds for the comprehensive services amendment. Shared funding of Community Support Programs (CSP) must be committed from top and clearly conveyed to state personnel."

-- Steven M. Fishbein, M.S., CRC

"The philosophy of service delivery is on target. There could be more discussion of the settlement models application to rehabilitation. This approach began with immigrants or outsiders and taught them to become a part of the system. Seeing the mentally ill as outsiders is a useful model, but one which must consider mental illness as barrier to inclusion in the mainstream. As such ample space must be left for those who will be unable to achieve a satisfactory adjustment in the new system.

The ideology espoused by the author needs to be linked to increased levels of effective rehabilitation. If this attitude and ambiance can be established as critical to rehabilitation, it can be used as an effective selection and training tool.

The CSP model is compatible with rehabilitation services. What needs to be considered is how to maintain control of rehabilitation services as boundaries begin to blur. Funding for rehabilitation services must begin to reconcile the sharing of roles and responsibilities with other disciplines."

-- Robert J. Grantham, Ph.D.

"Rubin's paper is very specific and as such it constitutes an excellent guide to those who would follow in Fellowship House's footsteps - the rationale and how-to of various service approaches are presented with clarity and in useful detail.

His approach implies, in terms of research direction, that we ought to ask: What is similar about this population (the chronically mentally ill) and others we have serviced previously, and what worked with those similar populations and how may it be applied to this population?

Rubin is correct in identifying a long list of disincentives, but while he recognizes that those who opt for SSI rather than employment should not be tagged welfare malingerers, he does not appear to pay adequate attention to the complex issues involved, from the public's view, in assuring ongoing financial support while encouraging work trials. The thin lines between earnings and welfare faced by so many of the working poor make the issue of income maintenance for the mentally restored a problem which cannot be resolved as a separate issue but rather needs attention as part of the total manpower policy balance between jobs and welfare in America today."

-- Sheila H. Akabas, Ph.D.

CHAPTER SIX

POST-EMPLOYMENT SERVICES: AN ESSENTIAL APPROACH IN THE REHABILITATION OF THE MENTALLY DISABLED

AUTHORS: JEROME RADIN, Ph.D. AND HARRY SANDS, Ph.D.

EDITOR'S NOTE AND SUMMARY OF PAPER

The following was an invited paper and ties in significantly to a renewed emphasis for the mentally ill person. It is based on a recently developed state-of-the-art monograph and other findings as part of a three-year research grant to the Postgraduage Center for Mental Health (New York City) from the National Institute on Handicapped Research. This paper presents a brief historical and legislative sketch bringing us up to the decade of the 80's, i.e. where we have been and where we need to go, as it concerns the mentally ill once they are placed or find competitive employment. Also discussed are the counselor's role, the issue of dependency, social networks and the reasons why post-employment services are especially vital to the rehabilitation process for the severely mentally disabled person.

INTRODUCTION

No other problem facing our society affects as many families as the plight of our citizens with chronic mental illness. Current estimates of men and women in the United States who have experienced serious psychiatric disability range from one and one-half to two million. Unfortunately, many of these people are released from institutions only to be "dumped" into communities with minimal or no appropriate facilities and programs to assist in their total adjustment. All too often, these persons exist in a "psychiatric limbo," jobless, homeless and often hungry.

Of the many obstacles facing the severely mentally disabled population, gainful employment continues to be a major problem. To compound this issue, these persons may also have difficulties holding a job after they have achieved employment.

This paper focuses on an essential rehabilitation tool known as Post-Employment Services. While not a new concept as such, its current use and attention has been stimulated by Federal rehabilitation authorities.

POST-EMPLOYMENT SERVICES (PES): A NEW EMPHASIS

PES (classified as Status 32 in the State-Federal Rehabilitation Program) were first legislated in the Rehabilitation Act of 1973 (PL 93-112) to assist in maintaining employment. PES are included in State and Federal operating

manuals, Federal position papers and Congressional testimony. However, the acceptance of PES as a standard procedure is not borne out in practice on the service level. According to RSA Commissioner Robert R. Humphreys, "On the whole, post-employment services are not being provided to former clients to any appreciable degree." This is quoted from an RSA Information Memorandum (1978).

The provision of Post-Employment Services (PES) is a fairly recent development in vocational rehabilitation and a service whose time is long overdue. PES is essential to the rehabilitation of the severely handicapped and particularly for maintaining the successful rehabilitation of the mentally disabled.

It should be noted that in 1977, an RSA Strategy paper called attention to the following questions:

a. What arrangement of the service delivery system for the ex-mental patient is necessary to maintain the client for the job?

b. What is the nature and format for follow-along services for the ex-mental patient beyond the standard follow-up period?

c. What are the emotional and personal aspects of job situations which are necessary for maintaining a job and the development of techniques to assit the client in developing skills in these areas so that the job can be maintained?

RSA thus recognized that new knowledge and techniques must be developed to determine the psychosocial and emotional demands of employment on the mentally disabled and the kinds of PES necessary to enable the mentally disabled to cope with those demands.

THE MENTALLY DISABLED: PROBLEMS IN JOB MAINTENANCE

It is widely recognized that a work setting can provide a mentally disabled client with an excellent arena in which to use his or her abilities and capacities in mastering reality. Further, success as defined by earnings, personal satisfaction gained from performing a job to established standards and interaction with fellow employees, all break the cycle of illness and hopelessness and are ego-strengthening for the rehabilitant.

Yet employment, while a significant achievement for the client, also represents a significant change in adaptation and lifestyle. In any change, even one that is beneficial to the individual, anxiety and internal conflicts are likely to be aroused that may challenge even this positive change. The anxiety and conflicts in the work setting thus become a barrier to one's rehabilitation. With this in mind, clients' responses at the start of employment have often been observed to include:

1. A tendency to react to the stress of employment by retreat and isolation;

2. An increase in regression and decompensation behavior;

3. Difficulty in reality testing;

4. Temporary loss or reduction in the use of life-coping skills;

5. Temporary loss or reduction in the use of social skills and support networks;

6. Tendency to either underestimate or overestimate one's own capacities in work and other areas of life; and a

7. Tendency for problems in one area to extend to other areas of life.

POST-EMPLOYMENT SERVICES: ISSUES TO BE RESOLVED

Many mentally disabled rehabilitants are thus in need of PES which can help stabilize them in their jobs. Yet there are still wide variations in the understanding and application of PES among clients, counselors and mental health personnel. In each group, there are some who look to PES to help, others who ignore PES and still others who do not know exactly what it is or how to use it.

Accordingly, PES issues to be resolved are associated with the following:

1. A clear definition of PES (what is it?);

2. Selection criteria for the application of PES (who should receive it?);

3. Kinds of PES problems anticipated (what are the client's needs?);

4. Operating criteria for initiation (when to apply PES?);

5. Determining the point of termination (when to end PES?); and

6. Evaluating the results of PES.

DEFINITION OF PES

There are two basic conditions for applying PES: either a one-episode service geared to meet an unexpected need arising from employment or the anticipated plan for PES prior to job placement.

One-episode application of PES requires an on-the-spot appraisal of the nature of the service need and the impending peril to job maintenance of the client. The principles for determination of this instant of PES are (1) there is a genuine need of the client that endangers the maintenance of employment if unmet, and (2) the individual or other resource is not able to meet that need.

The second rationale for determination of PES rests on the specific needs of mentally disabled rehabilitants. To anticipate and plan for PES for the client prior to job placement requires a system of assessment that carefully weighs the relative balance of the client's capacities and problems relative

to job placement and maintaining the job. Obviously, residuals of mental illness that prevent the client from attaining the job skills necessary for adequate vocational placement call for different kinds of interventions from those difficulties of the client as he or she begins an employment experience. The ability to function as a worker in a given work environment should be stressed in the judgment of PES planning beyond those problems strictly related to job skills themselves, e.g. ability to deal with authority figures, peers and potentially inappropriate behaviors.

SELECTION CRITERIA FOR PES APPLICATION

Determining who needs to receive PES among the mentally disabled will require the development of behavioral and other assessment indicators of client's work strengths and weaknesses. This will free the counselor from depending upon subjective and untested judgments.

Some data are currently available for identifying critical factors on the job. For example, the initial crisis period after job placement for the mentally disabled usually occurs in the first months of employment (Sands and Radin, p. 68). Later critical events include changes of circumstances on the job, e.g. salary increases or decreases, lateral change of position, promotion, a new work setting and changes due to additional training (Sands and Radin, p. 69). Research studies indicate that there is a clustering around persistence of symptoms, a reduced capacity to cope with stress, difficulties with people in authority, peer or co-worker relations and the motivation of the client to tolerate anxiety without it disrupting either the work relationships and/or work productivity (Sands and Radin, pp. 69-70).

It is obvious that a complete assessment of the client's work potential and life adjustment needs is a complex and time consuming task. Yet, it is this type of evaluation that is necessary in assisting the rehabilitation counselor or placement specialist to anticipate the client's PES problems based upon one's current and past problems.

ANTICIPATING PROBLEMS

It is the responsibility of the vocational rehabilitation counselor to (1) identify what PES are needed for the client; (2) locate these services either within the Vocational Rehabilitation Agency or in an outside agency; (3) educate or prepare the client to utilize the service; and (4) educate the service provider to the PES needs of the client (Sands and Radin, p. 39).

When the service need at post-employment consists of a specific and concrete device or object, for example, a voice amplifier for a mentally disabled rehabilitant with a hearing impairment, the guidelines and criteria for identification are clear and direct. However, the majority of needed services for the mentally disabled usually involve the ramifications of one's behavioral difficulties. The effects of these behaviors may vary in kind, degree and may be contingent upon the nature of the job itself. They may be at different times manifest, overt,acute or chronic. In addition, the underlying forces that bring out emotional conflict resulting in mental dysfunctioning may vary from

client to client and from job setting to job setting. Obviously, some set of guidelines for counselors as to behavioral indicators or critical functions in work adjustment are necessary. For example, counselors should be alert to a client's complaints about the job. These may be the expression of underlying anxiety and fear which may eventually cause the client to leave the job and regress into psychic symptoms and a less mature stage of development.

One predictive factor may be the ways in which the client reacts to the counselor in certain situations or observable behavior while the client is in training or in a sheltered workshop. The client's behavior can alert the counselor to plan an intervention. This might involve brief psychotherapy or group support to deal with patterns which may interfere with a job or interpersonal relationships with co-workers, as well as authority figures.

CRITERIA FOR INITIATION OF PES

Current RSA guidelines exemplify the difficulty of initiating PES:

> Individuals must ... get in touch with the counselor, especially during the first year following the determination as rehabilitated, before leaving their job, if any problems arise jeopardizing their job or if they plan to leave their job. (Rehabilitation Services Manual)

Unfortunately, this guideline may lead to counselors waiting for clients to alert them of needs and problems that clients themselves may not objectively recognize. Clinical experience does not support the contention that a client will always know when he or she needs help and, therefore, this regulation may be simply unrealistic.

On the other hand, if a counselor alerts clients to the fact that they might run into difficulties, he or she may be creating a self-fulfilling prophecy which is also ego-weakening and could create more dependency on the counselor.

Research as to the most effective moment of intervention calls for a monitoring of the client's adjustment in a manner that allows for the client's independence in coping with his or her own problems while providing the supportive service that allows the client a "network of safety."

TERMINATING PES

RSA guidelines provide, in general terms, for the termination of PES based on one of three conditions:

1. Client improvement with relation to disability, independence of functioning, apparently secure employment due to suitable job performance, employee acceptance or to the level of client employability potential and the client's own initiative;

2. Client deterioration, making PES not applicable; or

3. Counselor judgment (unspecified).

The absence of clear-cut operational criteria and timing for selection and application of PES leaves the counselor without any standards for making a judgment. What constitutes success or failure and a rationale for termination are lacking. How to apply these criteria poses problems for the individual vocational rehabilitation counselor and limits the effective judgment of both the service provider and client.

EVALUATING PES RESULTS

PES should be evaluated continuously as it progresses. A system of feedback between the service provider, the vocational rehabilitation counselor and the client should be established. Helping the client learn how to assess progress toward holding one's job and the goals prescribed to do this are also crucial.

When a concerted effort is made to construct and test the proper indicators for PES and all other PES components, an evaluation system should naturally develop. This evaluation will have the added benefit of providing useful knowledge for describing adjustment patterns of the individual.

The very act of identifying a client's resources does, in itself, have tremendous ego-strengthening effects. Its positive impact on adjustment of daily living and the rehabilitative process, including PES, will need to be studied. At the same time, learning how to diagnose the signs of acting out or decompensation can, when followed by proper intervention, prevent the client's regression, the return of troublesome symptoms and eventual breakdown.

THE POSTGRADUATE CENTER'S PES STUDY

The Postgraduate Center for Mental Health, under a grant from the National Institute for Handicapped Research (initially funded by RSA), is currently developing and evaluating a psychodynamic-rehabilitation support system designed to assist the client in holding (maintaining) a job once placement is made. The PES used in this study were designed to provide psychosocial support to help severely mentally disabled rehabilitants overcome anxiety and conflicts associated with starting a new job or returning to the world of work after a period of non-employment. The two PES methods developed are a special support system therapy and a systematic follow-up service.

SUPPORT SYSTEM THERAPY

The special therapy currently being used focuses on job maintenance (holding a job). Essentially, we teach clients to use a peer network to overcome their difficulties with the beginning stages of work and the withdrawal of rehabilitation counseling support.

Our time-limited special dynamic group (and individual) therapy focuses on the work oriented needs and problems of rehabilitants. It recognizes the special needs of this population in fulfilling the demands of a job. The clients are helped to develop greater capacities in coping with the world of work, ego-integration, attitudes and motivation. The development of these areas are necessary to enhance job maintenance as well as for independent

living within one's community. Utilizing the research that has been done in assisting disadvantaged and disabled individuals learn to function effectively, we have stressed a combination of the following factors: establishing a clear set to goals, assessing individual growth and improvement, increasing responsibility for one's own activities and providing a supportive group and peer environment (Gagne, p. 290).

The use of the group setting, we feel, is fundamental. While experimental date from our current study are not yet available, it is our belief that in the group setting, clients gain, by careful preselection, peers who will reinforce and aid one another in reaching individual work and other goals. For those clients with either previous poor group experiences or no active social network, the group provides a "starter" situation. Members begin to associate with each other before and, with encouragement, after group meetings. Clients learn how to reach out and are rewarded and supported in each effort to build more bridges to others.

During the sessions, the group leader, because of the special vulnerability of these clients to emotional eruptions and sudden decompensation, focuses attention on certain factors and avoids others, as shown below:

Group Attention	Group Avoidance
- here and now events	- past history of individuals
- work life (current)	- uncovering of rage and anger
- home life (current	- stimulating old associations involving fantasies
- the group itself	- reinforcing rigid patterns, habits and relationships

The group setting and the manner in which it functions provides the clients with rich experiences both individually and as a member of a social network. Each client has his or her own job and life goals to work on with the help of the group and group members. At the same time, the group provides opportunities for modeling, that is, identifying with the experiences of other group members. Each opportunity to define and determine new and better ways to deal with problems of work such as relating to authority figures or co-workers involves the interest and care of the others in the group, the thinking and experience of all and a safe place to learn, practice and try out new ideas and methods. As a consequence, we observed that there is a reduction in panic, fear and anxiety, and an increasing focus on reality and more productivity as clients learn to use their own resources in behalf of their own rehabilitation.

Practical solutions for real problems are the work of the group, and techniques for handling problems in an ego-integrated way are devised and used in a problem-solving manner.

The group is useful to one another in a variety of ways. It is reality-oriented and group members constantly bring each other back to the reality of the situation at hand. Group members become desensitized to some anxiety-provoking situations as they discuss them. There is immediate feedback from the client's peers. Sometimes members rehearse or role-play an upcoming situtation. For example, role-playing was used in one group for a client who had lost her job and was about to be interviewed for another. Through the techniques of rehearsal for the interview, the individual and the group members benefited as follows: There was a reduction of anxiety, the individual tested out her capacity to act in the real situation, members reached out and supported her, the resources of the individual and the members were brought out and members placed more reliance on each other, reducing their dependence on the group leader.

All these techniques served to interrupt pathological thinking and obsessional ideas that interfere with reality. Clients are encouraged to reach out to the peer network between group sessions and learn to prevent isolation.

FOLLOW-UP SERVICE

In the follow-up service of the Postgraduate Center, clients are interviewed by social workers via telephone. They have been trained to detect signs of anxiety, panic or other difficulties on the job and to help the client deal realistically in order to maintain themselves at work. Intervention can also take the form of referral for additional services.

We view the follow-up services as providing a supportive bridge for communication, one that aids the client to ventilate work associated anxieties and function better on the job, to utilize community resources effectively, to learn to develop more self-help or internal resources, to recognize early warning signals of regressive behavior which may lead to a breakdown and to provide a range of intervention services. The regularity of contact by the same follow-up worker provides a climate of support and linkage for the client that helps the person become more familiar with the work-a-day world and increase the prospects for independent living in the community.

SUMMARY

Post-employment services (PES) is viewed as a combination of follow-up and follow-along services after a client's case has been closed as rehabilitated. It is noted that the mentally disabled person may have complex needs that continue even after gainful employment has been obtained. The purpose of PES is to assist the client in maintaining or holding on to the job, thereby preserving any gains made during the earlier phases of the rehabilitation process. PES should be viewed as an integral part of the rehabilitation plan, especially in cases where a variety of behavioral indicators may point to potential trouble spots, e.g. a past history of difficulties with authority figures, lack of persistence and follow through in the completion of tasks or any number of personal problems that could manifest themselves in a job setting. The use of peer and group supports are also proving to be an invaluable approach in PES in the reduction of anxiety.

Most importantly, PES requires an individualized approach, since what may work for one client may not work for another. The current research is testing the range of PES and the ways and means of assessing its quality and usefulness.

In the final analysis, the positive findings of the current study on PES should have considerable use in the rehabilitation of persons with mental disabilities. The use of PES on any widespread basis will need a renewed commitment not only by Federal and State funding sources, but by the local agencies and their multi-disciplinary staffs.

RECOMMENDATIONS

The following are recommendations abstracted from the state-of-the-art monograph by Sands and Radin (1979) and are directed primarily to Federal and State agencies.

1. Incentives should be provided to State agencies to expand and improve PES.

2. Indepth research is needed to assess the nature of the employed mentally restored person, the work related problems and the PES program.

3. Training programs should be provided in the use of PES for rehabilitation counselors and mental health personnel. This should be incorporated into mental health center training, continuing education programs and graduate school curricula for rehabilitation counselors and other social service oriented disciplines.

4. Establish and fund research and training centers in the area of mental health.

5. Research into the housing needs of the mentally disabled is needed.

6. A study of the financial eligibility requirement for PES are suggested.

7. The disincentives to PES should be analyzed.

8. Improved guidelines and regulations need to be developed for PES by Federal and State agencies.

If the mentally disabled are to be better served in the next decade, the above recommendations, if implemented, should enhance the rehabilitation process for one of the largest disability groups in the United States.

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EDITOR'S COMMENTS

This paper provided some of the preliminary findings and ideas of a three-year project at the Postgraduate Center for Mental Health located in New York City. The project was funded by the Rehabilitation Services Administration (RSA) of HEW in 1977 and is currently funded by the National Institute of Handicapped Research (NIHR) to assess post-employment services to mentally disabled persons.

The first year's work resulted in the publication and dissemination of a state-of-the-art monograph entitled: The Mentally Disabled Rehabilitant: Post-Employment Services.

The second and third years of this project include the development and evaluation of a psychodynamic support system for recently employed former psychiatric patients who were clients of the New York Office of Vocational Rehabilitation.

The final results of this study should add significantly to our working more effectively with the mentally disabled. To maintain the rehabilitation gains made by the client has always been a challenge to the rehabilitation professional. For the mentally disabled person, this challenge becomes even more important.

The authors acknowledge the support provided by Grant No. 15-P-59125/2-03 from the National Institute of Handicapped Research, Department of Health, Education and Welfare, Washington, D. C. However, the opinions expressed herein are those of the authors alone.

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EPILOGUE

Several events have recently occurred in the United States that reflect a continuing concern for persons with problems of mental illness. The emphasis of the current Switzer Memorial Seminar and this monograph add to this special concern and provide further information in only a few major areas of the rehabilitation and rehabilitation of the mentally ill.

The events of significance include the following:

- The Dixon vs. Weinberger decision handed down by the courts which stated, in essence, that those who could benefit from community-based support should be released to less restricted settings appropriate to their individual needs.

- The White House Conference on the Handicapped, which convened in May 1977, has developed several volumes of information and recommendations. An implementation plan has been published and was based on 810 recommendations and 142 resolutions which were made primarily by consumers and consumer organizations. Many of these recommendations have direct applicability to those disabled by mental illness.

- The President's Commission on Mental Health was established in 1977 to review the mental health needs of the Nation and to make recommendations to the President as to how the Nation might best meet these needs. In 1978, this Commission produced four volumes of reports, including recommendations covering a broad spectrum of needs for the mentally ill.

- The signing of a cooperative agreement between the National Institute of Mental Health and the Rehabilitation Services Administration provided a vital linkage between two policy-making and funding organizations of government.

With the above described action and the awareness developed by these milestones, including the findings of the Fourth Switzer Memorial Seminar, we must evidence positive change in the decade of the 1980's in the rehabilitation of mentally ill persons.

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Despite the demands on the national and federal scene, her presence was almost ubiquitous in behalf of program development and extended services to needy people. On a regional, state or local level, be it public or voluntary services, if it were in the interest of rehabilitating those in need, somehow, she would "arrange to be there."

The WHO'S WHO has chronicled her many national and international awards. Also recorded are her presidencies of many organizations including NRA, whose members and their efforts she held in high esteem. But she did not reach the heights of her ability when she was made the first Administrator of the Social Rehabilitation Services, not when she retired from the position, nor when she became internationally involved in the World Rehabilitation Fund. Instead, she found her greatness when she touched each of us bringing our full humanitarian efforts and qualities to the fore in behalf of disabled and disadvantaged people. While readily recognized as a truly great administrator in the classical sense of the word, her true capacity and ability can only be appreciated when we realize that these accomplishments sprang from an inner expression of sensitivity, emotional refinement and dedication to serve all less fortunate people. Her egalitarian qualities were not contrived but spontaneous, stemming from love and respect for all living things.

All of us in NRA and in rehabilitation and all handicapped people have had better, more meaningful, and more productive lives because her presence and her being were sufficiently large to embrace and accept us as we are and help us better understand where we should be.

What more can be said than that we had the joy and privilege of knowing her?

This memorial tribute is quoted from E. B. Whitten, Journal of Rehabilitation, November/December, 1971.

MARY E. SWITZER MEMORIAL

To perpetuate the memory of a great woman and a great leader in the field of Rehabilitation by establishing a memorial that will expand and enrich services to handicapped individuals.